Dr Sajid Zaib

Quality Report

Oakfield Road
Aylesbury
Buckinghamshire
HP20 1LJ
Tel: 01296 423797
Website: www.oakfieldsurgery.co.uk

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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 of Dr Sajid Zaib (Oakfield Surgery) on 12 August 2015. Overall the practice is rated as good.

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

- We found the practice had made improvements since our last inspection on 17 December 2014 and they were meeting regulations relating to the management of medicines, recruitment, staffing and infection control that had previously been breached.
- 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.
- 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. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice demonstrated a strong commitment and constructive support to the three GP Registrars who were undertaking additional training at the practice, whilst gaining experience and higher qualifications in general practice and family medicine.
- The practice had an effective governance system in place, was well organised and actively sought to learn from previous CQC inspections, performance data, complaints, incidents and feedback.

Summary of findings

- The practice had a clear vision that had improvement of service quality and safety as its top priority. The practice fully embraced the need to change, high standards were promoted and there was good evidence of team working

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated locally and nationally to support improvement.

Systems and processes had been implemented following the previous inspection in December 2014. For example, we found medicines management reflected national guidelines, there was a robust recruitment process and appropriate infection control systems were in place.

The practice had policies in place for safeguarding vulnerable adults and children and all staff had received training relevant to their role.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence 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. The practice used proactive methods to improve patient outcomes and it linked with other local providers to share best practice. Staff had received training appropriate to their roles and any further training needs had been identified and training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Quality and Outcomes Framework (QOF) data available to us showed that the practice had higher than national and local average achievement levels. We looked at the QOF data for this practice which showed at 97.2%, the practice was performing above Aylesbury Vale Clinical Commissioning Group average of 95.1% and above the national average of 94.2%.

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.

Summary of findings

This was reflected in the data we looked at which showed positive patient feedback in relation to involvement in decisions about their care and treatment. The practice had good systems in place to support carers and patients to cope emotionally with their health and long term condition. Information to help patients understand the services available was easy to understand.

Support was available at the practice and externally for those suffering bereavement or that had caring responsibilities for others.

We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team, Clinical Commissioning Group (CCG) and Care Quality Commission to secure improvements to services where these were identified.

Patients said they found it easy to get through to the surgery and make an appointment with a named GP and that there was continuity of care. For example, 85% of patients found it easy to get through to the surgery by telephone. This was 10% higher than the local average. Urgent appointments were available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. We saw evidence learning from complaints took place.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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.

There was a level of constructive engagement with staff and a high level of staff satisfaction. The patient participation group (PPG) was active. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. For example, in December 2014 the practice was issued with a Care Quality Commission report which highlighted four regulatory breaches relating to the management of medicines, recruitment, staffing and infection control. We found all the actions had been completed at the inspection on the 12 August 2015. The practice had paid full heed to the report compiled by the commission, where action was required.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example, 100% of patients aged 75 or over with a fragility fracture were currently treated with an appropriate bone-sparing agent; this was significantly higher than the national average of 81%.

All patients over 75 had a named GP. Home visits were offered to elderly and frail patients. Patients at risk of an unplanned hospital admission had a care plan in place. The practice held registers for patients on palliative care and updated this regularly. All care plans for older patients were flagged in hospital correspondence. Older patients received regular medicines reviews. Older patients had access to a comprehensive range of carer's information at the practice, with many links to various support organisations. These included information on local befriending services and dementia support groups.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with long term conditions such as diabetes and asthma.

Performance showed practice performance for diabetes related indicators was significantly better than the CCG and national average. For example, 100% of patients with diabetes, on the register, have had influenza immunisation. The national average for this group of patients is 93%.

The percentage of patients on the diabetes register, with a record of a foot examination and risk classification was 97%; the national average is 88%.

Longer appointments and home visits were available when needed. All of these patients were offered a structured annual review to check that their health and medicine needs were being met. For those patients with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Summary of findings

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.

Childhood immunisation rates for the vaccinations given in 2014/15 were good for all standard childhood immunisations. Immunisation rates for under two year olds ranged from 94.6% to 98.6% and five year olds from 88.7% to 97.9%. These were similar to local and national averages.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside school hours and the premises were suitable for children and babies. We observed examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

The practice provided a range of appointments between 8:00am and 6pm Monday to Friday. The practice told us the practice had trialled Saturday morning appointments, however the uptake of these was very low. Although the practice did not provide extended hours, GPs told us they would see a patient past the normal hours if required. The practice offered telephone consultations for the working age population.

The practice was proactive in offering online services to all patients who were unable to attend the practice due to work commitments to book appointments, access a full range of health promotion and to order their prescriptions online.

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.

Summary of findings

The practice held a register of vulnerable patients including those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients had a personalised care plan in place. It offered longer appointments for patients that needed them.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for these patients.

The percentage of patients diagnosed with dementia who had their care reviewed in a face-to-face review was 93%; this was 10% higher than the national average.

The practice had good working relationship with the mental health crisis team. A counsellor saw patient's onsite, offering support with cognitive behavioural therapy and counselling sessions. A mental health register was maintained.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. There were 123 responses and a response rate of 39%.

- 85% of patients found it easy to get through to the surgery by telephone which is higher when compared with a CCG average of 75% and a national average of 73%.
- 79% of patients found the receptionists at this surgery helpful which is lower when compared with a CCG and national average of 87%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried which is similar when compared to both the CCG average of 90% and a national average of 85%.
- 80% of patients said the last appointment they got was convenient which was lower when compared with a CCG average and national average which are both 92%.
- 76% of patients described their experience of making an appointment as good which was similar when compared to both the CCG average of 76% and a national average of 73%.
- 83% of patients usually waited 15 minutes or less after their appointment time to be seen which was higher when compared with a CCG and national average were both 65%.
- 60% of patients felt they don't normally have to wait too long to be seen which was similar when compared with a CCG and national average which are both 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which were all positive about the standard of care received. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. They told us that long term health conditions were well monitored and supported. The patients we spoke with on the day of inspection confirmed this. They also explained how they felt listened to and understood their treatment and care.

Dr Sajid Zaib

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included an additional CQC Inspector and three specialist advisors (a GP, a Nurse and a Practice Manager) and an Expert by Experience.

Experts by Experience are members of the team who have received care and experienced treatment from similar services. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr Sajid Zaib

Dr Sajid Zaib practice is also known locally as the Oakfield Surgery and is located on Oakfield Road on the outskirts of the Aylesbury town centre. Dr Sajid Zaib practice is one of 19 practices within Aylesbury Vale CCG. The practice provides general medical services to approximately 5,000 registered patients in Aylesbury, Buckinghamshire.

The practice occupies a purpose built one storey building with onsite parking facility. All consulting and treatment rooms are located on the ground floor.

There are six GPs (two male and four female) at the practice comprising of two partners, one salaried GP and three GP Registrars. The practice is a training practice for GP Registrars. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

The all-female nursing team consists of one practice nurse and one health care assistant with a mix of skills and experience. In addition, the practice is supported by midwives who run clinics on the practice premises. The practice also works closely with district nurses.

A practice manager and a team of seven administrative staff undertake the day to day management and running of the practice. The practice has a General Medical Services (GMS) contract.

The practice population has a higher proportion of patients aged 40-65 compared to the national average. There is minimal deprivation according to national data. The prevalence of patients with a long standing health condition is 55% which is similar when compared to the national average of 54%. The practice population also includes a proportion of patients from the boating and canal community based at the nearby marina.

The practice is open between 08:00 and 18:30 Monday to Friday. The practice opted out of providing the out-of-hours service. This service is provided by the out-of-hours service accessed via the NHS 111 service. Advice on how to access the out-of-hours service is clearly displayed on the practice website and over the telephone when the surgery is closed.

The practice was previously inspected in December 2014 and we identified breaches in the regulations relating to management of medicines, recruitment, staffing and infection control.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was

planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We carried out a comprehensive inspection on 17 December 2014 and published a report setting out our judgements. We asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting. Therefore, the current inspection took place in order to follow up on the areas highlighted in the last inspection.

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 were 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 visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from Aylesbury Vale Clinical Commissioning Group (CCG), Healthwatch Buckinghamshire, NHS England and Public Health England.

We carried out an announced inspection on 12 August 2015.

During the inspection we spoke with five GPs, one nurse, one health care assistant, the practice manager, three members of the patient participation group, and members of the administration and reception team.

We reviewed how GPs made clinical decisions. We reviewed a variety of policies and procedures used by the practice to run the service. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

We obtained patient feedback from speaking with patients, CQC patient comment cards, the practice's surveys and the GP national survey.

We observed interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We found there was an open and transparent approach alongside clear procedures for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently and could show evidence of a safe track record. Lessons were shared to make sure action was taken to improve safety in the practice. For example, in June 2015 two patients with almost identical names and dates of birth were given the wrong medicines. An alert had been added to the computer system to all patients with the same or similar names. A revised process had been implemented to all reception staff and we saw evidence of reception staff clarifying all patients' demographics (names, addresses and dates of birth) on collection of prescriptions and booking of appointments.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

We saw that the lead GP initiated an audit or a records check when alerts were received relating to medicines or equipment used within the practice. The results were tracked and action taken and this was confirmed by the minutes we reviewed of the practice clinical governance meetings. The practice had managed safety consistently and could show evidence of a safe track record over the long term.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice had appointed a dedicated GP as lead in 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. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. This notice was displayed in the three main languages spoken by practice patients. All staff acted as chaperones and were trained for the role and had received a disclosure and barring check (DBS). (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).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked and calibrated in June 2015 to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.

Medicines Management

At the last inspection in December 2014 we found concerns in the systems the practice used to manage medicines. Specifically we found some medicines and consumables

were out of date and were not suitable for use. For example, we found five ampoules of adrenaline were out of date. We found consumables such as skin cleansing swabs and micropore surgical tape, were out of date.

Following the last inspection we received an action plan from the provider informing us of the action they had taken. We checked medicines kept in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records which confirmed this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential fridge failure. The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Patient Group Directions (PGDs) were available at the practice. PGDs are specific written instructions for the supply and administration of a licensed named medicine. There is a requirement for all PGDs to be signed at the time of issue. The PGDs we reviewed were all in date. 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 were kept securely.

Cleanliness and infection control

At the last inspection in December 2014 we found concerns in the systems the practice used to manage infection control. Specifically we found no evidence of infection control audits, staff had not received infection control training specific to their roles and we found no evidence of the Hepatitis B status for both the practice nurse and health care assistant.

During this inspection in August 2015 we observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had appointed a lead for infection control to enable them to provide advice on the practice infection control policy and to carry out staff training.

The named lead for infection control had a system in place to ensure that regular infection control monitoring was in place for clinical and non-clinical aspects of the practice. We saw evidence that the Infection Control Lead had carried out an infection control audit in August 2015. We saw evidence the practice continued to carry out regular infection control audits, revisit the areas of improvement and implement those changes. The practice had a plan to re-audit in six months.

The practice had trained staff on infection control by ensuring all staff had read the infection control policy and any updates from latest guidance were sent to relevant staff for review.

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. 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 to comply with the practice's infection control policy. For example, when handling specimens and during intimate or personal examinations.

There was a policy for needle stick injury and staff knew the correct procedure to follow in the event of an injury. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

Following the last inspection in December 2014 the practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections.

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.

Staffing and recruitment

At the last inspection in December 2014 we had concerns that patients could not be assured that they were supported or cared for by staff who had been suitably

recruited. This was because appropriate checks were not always completed before new staff commenced employment. Specifically three members of staff did not have a criminal record check made through the Disclosure and Barring service (DBS).

Following the last inspection we received an action plan from the provider informing us of the action they had taken. The practice confirmed they had taken appropriate action to ensure all staff were subject to suitable checks prior to commencing employment and these checks had been undertaken for all staff. The provider had maintained records of the recruitment checks they had undertaken.

This action had ensured that patients received care and treatment and support from suitably qualified staff who had been subject to appropriate recruitment checks by the provider, including a DBS check.

We noted the provider's recruitment policy had been amended to reflect the need for references where staff had previously worked in health or social care settings. Staff had received the checks required as result of these changes to the recruitment and staff background checking process.

During the inspection we spoke with several GP Registrars currently at the practice (GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine). They spoke of the quality of leadership and support received by all the practice staff, particularly the GP partners.

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 (AED) (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and the fire alarm system was serviced annually. The practice had carried out a rehearsal of their fire evacuation procedures and on the day of inspection we observed and heard testing of the fire alarm.

Processes were 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 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 utility companies to contact if the heating, lighting or water systems failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

GPs and nurses described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. 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 dementia were having regular health checks. Information collected for Quality Outcome Framework indicates 93% of practice patients diagnosed with dementia have had their care reviewed in a face-to-face review in the preceding 12 months. This was 10% higher than the national average.

Feedback from patients confirmed they were referred to other services or hospital when required.

We noted a good skill mix among the doctors with a number having additional qualifications and special interests. For example, one GP had a post-graduate certificate in dermatology; another GP was an approved trainer and appraiser. The GPs told us they led in specialist clinical areas such as diabetes, cardiology, children's health and obstetrics, the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff, not just the GP Registrars to review and discuss new best practice guidelines, for example, for the management of respiratory disorders.

The practice had a system whereby all referrals from the registrars were reviewed by the senior GP partner, and feedback on the outcomes of each referral was shared with the registrar.

The GPs told us they worked closely with external consultants and regularly sought their advice and support. For example, a GP described their contact with Healthy Minds Bucks (an NHS service offering quick and easy access to talking therapies and practical support for patients with depression, anxiety or stress) when caring for a patient with high level anxiety and another GP told us about an occasion when they sought advice from a haematologist at a local hospital.

The practice reviewed and discussed referrals during team meetings and improvements to practice 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 across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice used the electronic system to alert clinical staff to collect QOF data when patients attended for a consultation or a home visit was carried out.

Current results were 97.2% of the total number of points available, with 5.7% exception reporting. The practice scored higher than the national (94.2%) and local average (95.1%). The practice met all the minimum standards for

Good

Are services effective?

(for example, treatment is effective)

QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets. QOF data showed:

- Performance for diabetes related indicators was significantly better than the CCG and national average. For example, 100% of patients with diabetes, on the register, have had the influenza immunisation. The CCG average is 92.5% and the national average for this group of patients is 93%.
- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification was 96%. This was higher than both the CCG average 83% and the national average 88%.
- Performance for mental health related indicators was significantly better to the CCG and national average. For example, 100% of patients with schizophrenia, bipolar affective disorder and other psychoses have had a comprehensive, agreed care plan documented in the record. The CCG average is 82% and the national average is 86%.

Information about patient care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. Staff spoke positively about the culture in the practice around quality improvement.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. We saw evidence of a re-audit and second cycle of an audit on chronic obstructive pulmonary disease (COPD). The first cycle had been completed prior to our inspection in December 2014. The audits were carried out to identify the number of patients who were on medicine which increased the risk of pneumonia. Following each cycle, GPs completed medicine reviews. These findings were used by the practice to improve outcomes to patients.

Effective staffing

Practice staff included GPs, nurses, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended safeguarding vulnerable adults training and basic life support. We saw evidence that staff had received other mandatory training such as information governance, infection control and health and safety which were relevant to their roles.

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 which identified learning needs from which action plans were documented. We saw records in staff files of appraisals completed within the last twelve months and were shown a schedule of planned appraisals. Staff we spoke with confirmed that the practice was supportive in providing training and funding for relevant courses. For example, one staff member told us the practice was very supportive of training and professional development, and showed us evidence of the different courses they had completed. This included, ear syringing, aseptic technique, child safeguarding, adult safeguarding, chaperoning, infection control, basic life support and Doppler and dressings course. This staff member was supported by the practice whilst they studied an NVQ (National Vocational Qualification) level 2 in health and social care.

The practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. There were three trainee GPs working at the practice.

The practice nurse was expected to perform defined duties and was able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, removal of sutures, and cervical cytology. The practice nurse had additional extended roles for treating patients with conditions such as asthma, heart disease and diabetes. We saw they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

All new staff underwent a period of induction into the practice. Support was available to all new staff to help them settle into their role and to familiarise themselves with relevant policies, procedures and practices. We were shown the induction policy and an example of a comprehensive induction programme which had commenced in July 2015.

Working with colleagues and other services

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, 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 efficiency of the forum as a means of sharing important information.

The practice worked with other service providers to meet and manage patients' 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. Designated members of the administration staff held responsibility for ensuring communication from hospitals was passed to the GPs on the day they were received. GPs reviewed these communications each day and there was a system in place whereby each GP had a 'buddy' to review communications in their absence. The GP seeing these documents and results was responsible for the action required.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were in place for making referrals. The practice sent most of its secondary care referrals to the Stoke Mandeville hospital, and the tertiary referrals to the Oxford hospital (tertiary referral is the referral of a patient by an NHS consultant in one trust to a colleague in another trust outside of the local care contract, for the evaluation or provision of care). A copy of the referral letter was printed and checked by the GP before the referral was processed by the secretary.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS Web 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 Acts 2004. All staff we spoke with were conscious of their duties in fulfilling both acts. The GPs and practice nurse we spoke with understood the key parts of the legislation and described how they implemented it in their practice.

During our discussions staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The GPs and practice nurses demonstrated a clear understanding of the Gillick competency test. The lead GP demonstrated a comprehensive understanding of Gillick competency. (These were used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for recording consent for specific interventions. For example, GPs and nurses obtained written consent for joint injections, ear syringing and cryotherapy. Verbal consent was taken from patients for routine examinations.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

The practice followed guidance and local initiatives set by the CCG to meet 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.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. One GP showed us how patients were followed up as appropriate if they had risk factors for disease identified at the health check and how they scheduled further investigations.

We saw plans for a private area away from the reception which would be known as the health promotion pod. All patients would be able to access this area throughout the course of the day. Plans for this area included several pieces of equipment which patients could to use to manage and record their height, weight and blood pressure.

There was a range of information available to patients on the practice website including the services available at the practice, health alerts and latest news. The website included links to a range of patient information, including for travel immunisations, NHS health checks and the management of long term conditions.

The practice had identified the smoking status of 95% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was a range of patient literature on health promotion and prevention including local smoking cessation information available for patients in the waiting area.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic cervical smears. The practice's uptake for the cervical screening programme was 81.3%, which was slightly higher than the CCG average of 77.7% and the national average of 74.3%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening, this was reflected in data from Public Health England:

• 58% of patients at the practice (aged between 60-69) had been screened for bowel cancer in the last 30 months; this was similar to the CCG average of 59% and the national average of 58%.

• 72% of female patients at the practice (aged between 50-70) had been screened for breast cancer in the last 30 months; this was slightly lower than the CCG average which was 77% and equal to the national average which was also 72%.

The practice kept a separate list for all pre-school child immunisations. This list was downloaded manually by an administrative staff member, to ensure no one was missed off the list. The practice received a weekly list of all child immunisations from the Child Health Department, and appointments were booked in accordingly.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94.6% to 98.6% and five year olds from 88.7% to 97.9%. This is similar to the CCG immunisation rates which ranged from 91.8% to 97.7% for under two year olds and 92.8% to 97.1% for five year olds.

Last year's performance for all influenza immunisations was higher than CCG average and the national average where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 74.4%, and at risk groups 51.9%. These were above CCG and national averages.
- Flu vaccination rates for patients with diabetes (on the register) was 100% which was above the national average of 93.5%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Staff were mindful of the practice's confidentiality policy when discussing patients' confidential information to ensure that it was kept private. Phone calls from patients and other healthcare professionals were taken by administrative staff in a separate area where confidentiality could be maintained. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We observed staff interacting with patients in the reception, waiting rooms and on the telephone. All staff showed genuine empathy and respect for people, both on the phone and face to face.

We saw how a vulnerable patient was appropriately supported by staff to attend their appointment at the practice.

All of the 25 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. We also spoke with three members of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice had similar satisfaction scores to the local and national averages for consultations with doctors and nurses.

For example:

- 85% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 94% said the nurses gave them enough time compared to the CCG average of 93% and national average of 92%.
- 100% said they had confidence and trust in the last nurse they saw or spoke with. This was slightly higher than the CCG average 98% and national average 97%.

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:

- 85% said the last GP they saw was good at explaining tests and treatments which was similar when comparing to the CCG average of 88% and national average of 86%.
- 82% said the last nurse they saw was good at explaining tests and treatments which was slightly lower when compared to the CCG and national average, both of which were 90%.

Patients we spoke with on the day of our inspection told us 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. We saw notices in the reception areas informing patients this service was available. The practice self-check in service was available in different languages.

Patient and carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, the 2015 national GP survey showed:

Good

Are services caring?

- 95% of patients said the nurse they saw was good at treating them with care and concern. This was slightly higher than the CCG average 92% and the national average 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. This highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and 15% of the practice list had been identified as carers and were being supported, for example, by offering health checks and referral for social services support. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw leaflets available in the waiting room with information about how to access bereavement support.

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. A range of clinics and services were offered to patients, which included family planning, antenatal, and blood tests.

GPs would request longer appointments for complicated long term conditions to ensure patients had enough time to receive care and treatment. All GPs had access to specialists for further advice, and in particular had used haematologists and radiologists for additional advice on the health care needs of the patients at the practice. GPs placed all new patients who were diagnosed with a long term condition on the practice register and organised recall programmes accordingly.

The practice had trained the health care assistant (HCA) to offer patients regular services such ear syringing, dressings, flu immunisations and electrocardiograms (ECG). The HCA also ran blood test clinics and offered 10 minute appointments, to ensure patients had enough time to ask questions and seek appropriate advice. Any concerns identified were referred to the patient's GP. Patients benefited from a stable staff team because staff retention was high, which enabled good continuity of care and accessibility to appointments with a GP of choice. All patients needing to be seen urgently were offered same-day appointments.

Access to the service

The practice offered a range of appointments to patients every weekday between the hours of 8.00am and 6:30pm. The practice closed during lunch time from 1pm until 2pm. If patients called during this time, a recorded voice message explained what to do in the event of an emergency or if the call required the urgent attention of a GP. During this hour telephones were monitored by the reception staff for urgent calls and transferred straight through to a designated and available GP. Patients were able to book an appointment to see a GP or nurse by text, telephone, online and in person. Patients were able to book a double appointment by choice or when requested by the GP or nurse for complicated conditions. Home visits were made to those patients who needed one.

The practice did not provide extended opening hours, during the week or at the weekend. The senior GP partner told us the practice had trialled Saturday morning appointments, however the uptake of these had been very low. Staff told us all GPs had allocated urgent appointment slots after each surgery. The reception staff told us the current appointment system worked very well and the practice was able to meet patient demand.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages. Patients we spoke with on the day and completed comment cards also indicated their satisfaction with the level of access. For example:

- 85% find it easy to get through to this surgery by phone which is higher when compared with a CCG average of 75% and a national average of 73%.
- 87% were able to get an appointment to see or speak to someone the last time they tried which is similar when compared to both the CCG average of 90% and a national average of 85%.
- 83% usually wait 15 minutes or less after their appointment time to be seen which is higher when compared with a CCG average of 65% and a national average of 65%.

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.

Information on how to make a complaint was provided on the practice website and practice leaflet.

The practice had a complaints procedure and this was displayed in the waiting area. This allowed patients to make an anonymous complaint and also provided information to patients on how to escalate the complaint further if not satisfied with practice response. The practice had systems to review complaints received by the practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

and ensured they had learnt from them. All incoming complaints were reviewed during the monthly protected learning time meeting. Staff told us reviewing complaints was viewed as a learning tool for all staff at the practice. We saw evidence of an annual review of all complaints completed by GP partners and practice manager.

The practice could then identify any patterns and shared the learning with the GPs and nurses. The minutes of these meetings demonstrated a discussion of the complaints and the relevant learning points.

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 business development plan. This set out the practice values, aims and objectives for the next five years. The practice values included, promoting a learning culture within the practice and to deliver high quality care and promote good outcomes for patients.

The practice charter was displayed and was available on the patient website. We saw the values included to provide safe and effective high quality care and to ensure the practice is effectively led and managed and staff received relevant education, training and development. The staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and support the safe running of the practice, these were available to staff via the IT system. We looked at seven of these policies and procedures, all policies had been reviewed annually, version controlled and were up to date.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies such as the induction programme, health and safety policy, disciplinary procedures and grievance process which were in place to support staff. We saw the staff handbook that was available to all staff, which included sections on equality and whistleblowing. Staff we spoke with knew where to find these policies and the staff handbook if required.

All staff we spoke with had a comprehensive understanding of the performance of the practice. The governance arrangements in place were designed to support the practice as it grew, in the number of services it provided as well as the number of patients it served.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff told us there was an open and relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues. Staff said they felt respected, valued and supported, particularly by the partners and management in the practice.

The management team in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care.

Staff told us that regular team meetings were held. All staff were involved in discussions about how to run and develop the practice, and the GP partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, public and staff

We found the practice to be involved with their patients, the patient participation group (PPG) and practice staff. We spoke with three members of the PPG and they were positive about the role they played and told us they felt engaged with the practice.

There was evidence of regular meetings and PPG members' involvement in undertaking practice supported initiatives. The PPG had regular fundraising events with a view of purchasing equipment for the practice. We saw evidence of the PPG had purchased various pieces of equipment. For example, a Doppler, a device which can be used to measure blood flow to help the treatment of leg ulcers.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

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 three staff files and saw that regular appraisals took place which included personal development plans. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults.

Are services well-led?

Good

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

Staff told us that the practice was very supportive of training. One member of staff told us about several different training sessions they had attended.

The practice was a GP training practice. We spoke with two GP registrars who spoke of the quality of leadership and support received at the practice. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

In December 2014 the practice was issued with a Care Quality Commission report which highlighted four regulatory breaches relating to the management of medicines, recruitment, staffing and infection control. We received an action plan from the practice which outlined the corrective action they would take. We found all the actions had been completed at the inspection on the 12 August 2015. The practice had paid full heed to the report compiled by the commission, where action was required. For example implementing effective infection control procedures and actions.