Care Quality Commission

The Mockett's Wood 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 The Mockett's Wood Surgery on 26 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, responsive, caring and well-led services. It was outstanding for providing services to older people and was good for providing services to people with long-term conditions, families, children and young people, working age people (including those recently retired and students) and for people whose circumstances may make them vulnerable. It was also good for providing services to people experiencing poor mental health (including 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. 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 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 urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- 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.

We saw an area of outstanding practice:

- The practice had developed an initiative for older patients over the age of 75 with a purpose of providing an integrated and joint working approach in multi-disciplinary care, to reduce unplanned / emergency hospital admissions. A 'care co-ordinator' had been employed to organise the care and treatment interventions for this patient group and was the single point of contact for patients, their carers and community health and social care professionals. The care co-ordinator organised and arranged interventions and support from community multi-disciplinary teams and clinical support from the GP when required.

Available data indicated that unplanned / emergency hospital admissions for the previous six months were one of the lowest compared to other practices in the area.

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

The provider SHOULD:

- follow the practice recruitment policy to ensure sufficient documented information is available in relation to the employment of staff – including information about references
- review the staff training requirements in relation to the Mental Capacity Act 2005.

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?
The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. They monitored safety and responded to identified risks. Lessons were learned and shared to support improvement. The practice had policies to safeguard vulnerable adults and children who used the services. Risks to patients were assessed and well managed. Sufficient numbers of staff with the skills and experience required to meet patients' needs were employed.

Good

Are services effective?
The practice is rated as good for providing effective services. The majority of 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 (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received annual appraisals and training appropriate to their roles. Further training needs had been identified and planned. Staff worked with multi-disciplinary teams and community specialists to provide effective care and treatment for patients.

Good

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

Good

Are services responsive to people's needs?
The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified. For example, in responding to the needs of older people within the community. Patients said they found it easy to make an appointment with a named GP, with urgent appointments available the same day. The practice had responded to local need by offering twice weekly 'walk-in' sessions that did not require appointments and provided flexible arrangements in accessing health care services. The practice had good facilities and

Good

Summary of findings

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 discussed and shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a statement of purpose that set out the aims and objectives of the practice and staff were clear about their responsibilities in relation to these. 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 / practice 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. The patient participation group (PPG) was supportive of the practice values and had recently become active. Staff had received regular performance reviews and attended staff meetings and training / social 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

Outstanding 

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia care and in avoiding unplanned admissions to hospital. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice also supported local care home residents with their health care needs and a GP from the practice provided training to care home staff in supporting people with dementia and other conditions associated with older people's care.

The practice was caring in the support it offered to older people and there were effective treatments and on-going support for those patients identified with complex conditions, such as dementia and conditions associated with end of life care. All patients over the age of 75 had a named GP who was responsible for their care and treatment.

A member of staff was employed at the practice as a 'care co-ordinator' to oversee and initiate joint working arrangements with other health and social care professionals and to provide a single point of contact for older patients. Multi-disciplinary care planning provided an integrated approach to care and support for older people and their carers. Other members of staff had taken on extended roles to support the care co-ordinator in setting up the project and available data indicated that the new arrangements had made a positive difference for patients. For example, unplanned / emergency hospital admissions for the previous six months were one of the lowest compared to other practices in the area.

Annual influenza vaccinations were routinely offered to older people to help protect them against the virus and associated illness.

People with long term conditions

Good 

The practice is rated as good for the population group of people with long term conditions. The practice offered nurse led specialist clinics and appointments including asthma, chronic obstructive pulmonary disease (COPD) and diabetes clinics. The practice had systems to alert staff to patients at higher risk of unplanned hospital admissions and they were identified as a priority.

Summary of findings

Longer appointments and home visits were available for patients with long-term conditions and annual reviews were arranged to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health care professionals to deliver a multi-disciplinary package of care.

We saw that influenza vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for families, children and young people. Expectant mothers were supported by the midwife linked to the practice and mother and baby clinics were offered for post-natal care as well as baby checks with the GP. There were systems in place to identify children who may be at risk and safeguarding procedures to ensure any concerns were followed up.

Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

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 and flexible. For example, the practice had introduced 'walk-in' GP sessions that did not require appointments.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

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 had supported people living in vulnerable circumstances, including homeless people and travellers. There were flexible arrangements in registering them at the practice on a temporary basis if they preferred.

The practice had a lead GP who supported people with learning disabilities and clinics were offered at the practice with the community learning disability nurse. Annual health checks for people with a learning disability were undertaken.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people, for example, those with drug and alcohol problems and informed them about various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults, were aware of their responsibilities in relation to information sharing and recording 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 was rated as good for patients experiencing poor mental health. The practice had procedures for identifying patients who had mental health needs and regular checks were offered and follow-up contact was made where patients had not attended for appointments. The practice was responsive in referring patients to other service providers, for example, the community mental health team. There was a range of information available for patients who may require additional support and services. The practice staff had been made aware of how to respond and prioritise appointments for people with mental health needs and adopted a flexible approach in the support it offered, including referral and information regarding crisis support.

The practice worked with multi-disciplinary teams and community specialists in providing support to patients with dementia and had a lead GP who specialised in supporting this patient group. The practice had increased its screening and dementia assessments and undertook six monthly reviews of patients diagnosed with dementia

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection, all of whom told us they were satisfied with the care provided by the practice. They told us they felt listened to and involved in decisions about their care and treatment and said that referrals to other services for consultations and tests had always been efficient and prompt.

Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. They were very complimentary about the staff, and said they were always caring, helpful and efficient, and that they were treated with respect and dignity at all times.

Patients told us the appointments system worked well and that they would be able to get same day appointments if urgent. Some patients commented about the twice weekly 'walk-in' sessions that were held at the practice, saying that these were particularly convenient and provided a flexible approach to seeing a GP. Patients told us that they were able to get through to the practice on the telephone to make appointments, whilst others told us they had successfully used the online appointments system, as well as ordering repeat prescriptions online.

Patients we spoke with told us they knew how they could access out of hours care when they required it and had also received telephone consultations from the practice GPs.

We looked at 34 patient comment cards that had been completed prior to the inspection and they contained very positive comments about the practice staff and the care received.

We reviewed the comments from the 2013/14 national patient survey and the practice had been rated well in all areas, including 90% of respondents who said that the last time they saw or spoke with a GP, they were good or very good at treating them with care and concern and 91% said the GP was good or very good at involving them in decisions about their care.

Areas for improvement

Action the service SHOULD take to improve

- follow the practice recruitment policy to ensure sufficient documented information is available in relation to the employment of staff – including information about references
- review the staff training requirements in relation to the Mental Capacity Act 2005

Outstanding practice

- The practice had developed an initiative for older patients over the age of 75 with a purpose of providing an integrated and joint working approach in multi-disciplinary care, to reduce unplanned / emergency hospital admissions. A 'care co-ordinator' had been employed to organise the care and treatment interventions for this patient group and was the single point of contact for patients, their carers and community health and social care professionals. The care co-ordinator organised and arranged interventions and support from community multi-disciplinary teams and clinical support from the GP when required. Available data indicated that unplanned / emergency hospital admissions for the previous six months were one of the lowest compared to other practices in the area.

Care Quality Commission

The Mockett's Wood 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 specialist advisor, a practice manager specialist advisor and a practice nurse specialist advisor.

Background to The Mockett's Wood Surgery

The Mockett's Wood Surgery provides medical care Monday to Friday from 8am to 6.30pm each week day and operates extended opening hours from 7.30am on Tuesday mornings, and until 7.30pm on Tuesday evenings, as well as alternate Saturday morning clinics. The practice is situated in the coastal town of Broadstairs in Thanet, Kent and provides a service to approximately 7,000 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. The practice has significantly more patients in the older people population group than both the local and national average. There are also a higher number of people in the newly retired age group and the practice has fewer children and young people under the age of eighteen than both the local and national averages. The number of patients in all age groups recognised as suffering deprivation is lower than both the local and national averages for this practice.

The practice has three GP partners, one female and two male and employs two female practice nurses, and one female health care assistant. There are a total of seven administration, secretarial and reception staff and a practice manager.

The practice does not provide out of hours services to its patients and there are arrangements with another provider (the 111 service) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

The Mockett's Wood Surgery

Hopeville Avenue

St Peters

Broadstairs

Kent. CT10 2TR

Why we carried out this inspection

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

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.

This provider had not received a comprehensive inspection before and that was why we included them.

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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 February 2015. During our visit we spoke with a range of staff, including three GPs, one nurse and a health care assistant, three members of the administration team, the care co-ordinator and the practice manager. We spoke with patients who used the service. 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 had systems and procedures for identifying, reporting and recording incidents. There were arrangements for monitoring safety, using a range of information, for example, from audits and checks that were undertaken by staff and from comments and complaints received from patients. Staff we spoke with were able to describe their responsibilities in relation to reporting incidents and concerns and told us they knew the reporting procedures within the practice. We saw examples of incidents that had been recorded by staff, for example, an incident concerning the delivery of vaccinations that had been reported and recorded as a clinical incident.

We reviewed the summarised incident reports for the previous year and minutes of meetings where these had been discussed.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Staff told us that there were systems to help ensure the practice learnt from significant events and we saw that these were discussed regularly at practice meetings.

We looked at the significant events recorded for the previous and current year which were held in a summarised format, identifying the actions taken, the outcome following any investigation and the changes made within the practice as a result. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Actions were taken as a result, for example, a new protocol had been implemented to help ensure the treatment pathway for a specific health related condition was followed. Significant events were discussed amongst the GPs and nursing staff if urgent action was required and then reviewed at the weekly / monthly practice meetings. Staff were aware and involved in the process, knew how to raise an issue for consideration at the meetings and felt encouraged to do so.

National patient safety alerts were received by the practice manager and shared with relevant staff electronically on the computer system and were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

There were systems and processes to manage safety within the practice, including arrangements for safeguarding vulnerable adults and children who used services. The practice had policies for safeguarding children and vulnerable adults and these clearly set out the procedures for staff guidance and contact information for referring concerns to external authorities. Policies reflected the requirements of the NHS and local authority safeguarding protocols and included the contact details of the named lead for safeguarding within the NHS and details of the social services area team.

Staff told us that there was a GP within the practice who was the designated lead in overseeing safeguarding matters and we saw that this was included in the policies for staff information and guidance. GPs, nurses and administrative staff we spoke with were knowledgeable in 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 safeguarding concerns and how to contact the relevant agencies in working hours and out of hours. Staff told us they had received training in safeguarding vulnerable adults and children and we saw records that confirmed this. Records demonstrated that GPs had the necessary training to fulfil their roles in managing safeguarding issues and concerns within the practice. The practice staff had recently undertaken a safeguarding training event with members of a local multi-agency group, to identify the concerns and issues that were specific to the local area, including the work of police and social services in relation to the protection of vulnerable young people.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. Staff told us that missed appointments for children would be followed up, for example, in relation to childhood immunisations.

The practice had a chaperone policy. A chaperone is a person who accompanies a patient when they have an examination and we saw that the practice policy set out the arrangements for those patients who wished to have a chaperone. We saw that this was clearly displayed in the reception area and in consulting rooms for patients'

Good

Are services safe?

information. Nursing staff, including health care assistants, had received chaperone training and we were told the practice planned to train administration staff to provide more flexibility in providing chaperones to patients.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Appropriate temperature checks for refrigerators used to store medicines had been carried out and records were kept.

Records showed that medicines held by the practice for use in emergency situations were checked regularly and the practice had a system to monitor and record all medicine stock levels. The practice did not keep controlled drugs.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of authorised directions and evidence that nurses and health care assistants had received appropriate training to administer vaccines.

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 and were kept securely at all times.

Cleanliness and infection control

The practice was clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow, for example, hand hygiene, management of clinical and hazardous waste, and safe handling of specimens.

Staff we spoke with told us they had received training in infection control and the training records confirmed this. They were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control. Personal protective equipment including disposable gloves, aprons and coverings were available and staff were able to describe how they would use these to comply with the practice's infection control policy.

A member of staff was the infection control lead for the practice and we spoke with them. They demonstrated a clear understanding of their role and responsibilities in relation to infection prevention and control and they had undertaken a range of infection control audits, for example, protective equipment, hand hygiene, and sharps injuries. Identified actions were monitored and discussed in clinical meetings, although these were not always recorded.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. We saw that domestic and clinical waste products were segregated and clinical waste was stored appropriately and collected by a registered waste disposal company. Information in relation to hand washing techniques and sharps injuries was displayed in treatment rooms for staff guidance. Cleaning schedules and records were kept and a safe system was used to manage the cleaning equipment. Staff told us that they cleaned clinical equipment in the treatment rooms on a daily basis and between patients, although they did not formally record this activity.

The practice had considered the risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings) and had undertaken an assessment to determine whether testing of the water systems would be required on a regular basis. Records showed that this would be reviewed on a six monthly basis to monitor any changes in the level of risk for the premises.

Equipment

Clinical equipment was appropriately checked to help promote the safety of staff, patients and visitors. Staff told us that equipment used in the practice was routinely checked and said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and we saw some records that confirmed this, for example, records to demonstrate that portable electrical equipment had been tested. We were told that as the clinical equipment in the practice was new, calibration checks would be undertaken as soon as necessary and plans were in place to do this.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff, including

Good

Are services safe?

protocols for checking qualifications, professional registration and obtaining references. Records showed that in most cases, recruitment checks had been undertaken when employing staff, for example, proof of identification, qualifications and registration checks with the appropriate professional body. However, of the staff files examined, some did not contain documented information in relation to interview notes, job descriptions and contracts of employment, as stipulated in the practice recruitment policy. Not all of the staff files we looked at contained two references, although these were for staff who had been employed at the practice for a number of years. Criminal record checks through the Disclosure and Barring Service (DBS) had been undertaken for the majority of staff, where the practice had assessed that this was appropriate to their roles, for example, for staff who undertook chaperone duties.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to help ensure that enough staff were on duty and arrangements 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 there were always enough staff to keep patients safe. Patients we spoke with told us they felt there were enough staff in the practice to support their care and treatment needs.

Monitoring safety and responding to risk

The practice had health and safety procedures and information was included in the staff handbook for guidance. Routine monthly checks of the building were undertaken and risks were identified and recorded. All staff were able to contribute to the 'risk evaluation' process by completing forms and reporting safety concerns for follow-up and discussion at practice meetings. For example, a protocol had been discussed and agreed to check that all required areas in the practice were locked and the keys safely stored at the end of each day.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. Emergency referrals were made for patients who had experienced a sudden deterioration or urgent health problem. Nursing staff we spoke with described occasions when they had referred patients urgently to the duty GP within the practice following routine clinic appointments, for example, a patient who experienced problems following a blood test.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew where they were kept.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, interruption to utilities, or unavailability of the premises.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that most staff had received fire safety training and that regular tests and checks of the building were undertaken.

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, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines and care pathways were discussed and shared with GPs and nursing staff, for example, a national influenza immunisation programme update and meetings where dermatology specialists participated to provide updated information on treatments.

The practice used computerised tools to identify patients with long-term conditions and complex needs. Guidance templates were used and embedded into the computer system to ensure GPs and nurses were using up-to-date assessment tools. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Management, monitoring and improving outcomes for people

The practice kept registers to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions, including dementia, asthma, heart disease and diabetes. Registers were kept under review and we saw meeting minutes where information was shared and discussed regarding the health care needs of specific patients and any additional risk factors that may need to be identified on the system. All patients over the age of 75 had a named GP who was responsible for their care and treatment and care plans were in place for this age group. Older people who lived in care homes were supported by the same GP from the practice, who held weekly sessions and attended as necessary. The GP had also provided training to care home staff in supporting older people with end of life care.

The practice had developed an initiative for older patients over the age of 75 and those at risk of unplanned admissions to hospital. A 'care co-ordinator' was employed at the practice to co-ordinate the care and treatment interventions for this patient group. They were the single point of contact for patients, their carers and community health and social care professionals. Information had been collated from patients and their carers using questionnaires. The information was used to assess patients' health, social and psychological care needs, to identify risk factors and to undertake dementia screening and assessment. Comprehensive 'person centred' care plans had been developed to produce an assessment of risk, based on the patient's overall needs and the contents agreed with patients and / or their carers. Risk ratings were used to monitor individual patients and indicated where interventions and support were required from community teams and specialists. There were indications that the new service had benefitted patients and had a positive impact. For example, available data for the previous six months indicated that unplanned emergency admissions into hospital for patients at the practice was one of the lowest when compared to other practices in the area.

Routine information coming into the practice was also shared with the care-co-ordinator to inform and update the risk ratings and to put in place additional care and support that patients required. For example, interventions from community health and social care professionals following attendances at hospital or out of hours care. The care co-ordinator also visited patients at home if they were unable to attend the practice and provided them with a telephone number for contact purposes. Multi-disciplinary meetings were held each month and individual patients' care was reviewed. Posters advertising the service had been produced for patient information and the care co-ordinator had also conducted a patient survey to obtain feedback about the enhanced service. The results showed that the majority of patients felt they had benefited significantly from the service, had been reassured that their care was being monitored and organised for them and that they found the practice innovative and caring in its approach. The practice also considered that the initiative had contributed to the reduced levels of hospital attendances for older patients and available data indicated this was the case.

The practice collected data for the Quality Outcomes Framework (QOF). QOF is a national performance measurement tool used by GP practices to measure and compare their performance to other practices on a local and national basis. The practice reviewed data collected for the QOF at weekly / monthly meetings with the staff, where regular discussions took place to monitor different performance areas within the QOF indicators. The available QOF data showed that the practice had achieved higher

Good

Are services effective?

(for example, treatment is effective)

performance than the national average in many areas, including care and treatment for patients with diabetes. For example, the practice had achieved 98% compared to the national average of 88% for patients with diabetes receiving a foot examination in the preceding twelve months.

Where the practice performed less well, for example, in some areas of anti-inflammatory prescribing, the practice was aware and had taken steps to address the issues. For example, GPs were reviewing new patients' medicines when they registered with the practice and discussed alternative options. The practice was also working with the clinical commissioning group (CCG) medicines management team, to help ensure the latest guidelines were used and a 'medicines management tracker' was used by the practice to monitor medicine prescribing.

The practice had a system for completing clinical audits, although these had been undertaken by medical graduates on behalf of the practice GPs. These included an audit to identify those patients at risk of a specific type of arterial disease. New clinical guidance had required these patients to be placed on a register to enable the practice to monitor and treat their condition appropriately. Following completion of the audit, a number of patients had been identified for follow-up appointments with the GPs, to review their treatment regimes. Changes to the computerised patient records system had also been required to introduce alerts for GPs to undertake assessments when treating patients who were at higher risk and to incorporate them onto the new register. A follow-up audit was planned for the coming year to review the on-going effectiveness of the changes made. Other recent audits had also been undertaken, for example, a prescribing audit in relation to patients at higher risk of kidney disease. Although patients at higher risk had been identified and medicine reviews undertaken, a second audit cycle had not been completed to fully review the impact of the changes made.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and the computer system provided an alert for those patients who required a medicines review.

Effective staffing

The practice staff team included GPs, nurses, managerial and reception / administrative staff. We were told by staff that they had completed mandatory training including basic life support, infection control, and safeguarding, and we saw records that confirmed this. GPs and nurses had also completed specialist clinical training appropriate to their role, for example, diabetes, asthma, family planning and updates in childhood immunisations.

Staff received annual appraisals and the staff we spoke with said they received the on-going support, training and development they required to enable them to perform their roles effectively. We saw records that confirmed annual appraisals had been undertaken for staff, that identified training and development needs and that actions were agreed / documented for the coming year. The lead nurse at the practice had links with the CCG training and development lead, who supported and advised in relation to continual professional development and future training needs had been identified, for example, a diploma in diabetes. The practice closed for training one afternoon each month, and provided protected learning time for staff.

A process for GP appraisal and revalidation was in place and we saw that dates were confirmed for annual appraisal and completion of revalidation for each GP within the practice. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Working with colleagues and other services

The practice had well established processes for multi-disciplinary working with other health care professionals and partner agencies. For example, GPs and nurses attended monthly multi-disciplinary meetings that included community nurses and the palliative care team who had specialist knowledge in long-term and complex conditions.

The practice care co-ordinator had developed joint working protocols and systems to help ensure all information in relation to patients over the age of 75 was appropriately shared and reviewed with relevant health and social care professionals. There were processes to communicate and work with community and other health care specialists, for example, the midwife linked to the practice, who supported patients throughout their pregnancy and the community

Good

Are services effective?

(for example, treatment is effective)

learning disability nurse, who undertook health care checks and assessments. The practice referred patients with mental health problems to the specialist mental health team and had links to the duty mental health specialist for patients in crisis.

The practice received blood test results, x-ray results, and letters from the local hospital (including discharge summaries), out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures for staff to follow in relation to passing information on, as well as reading and acting on any issues arising from communications with other care providers on the day that they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

Information sharing

There were effective systems to ensure that patient information was shared with other service providers and that recognised protocols were followed. For example, there was a system to monitor referrals made to hospital services and consultants. Follow-up checks were made within a set time frame to ensure referrals had been received and acted on. The practice care co-ordinator had also developed systems to help ensure referrals and information was shared appropriately and in a timely way with specialist services and other care providers for patients over the age of 75.

An electronic patient record system was used by staff to co-ordinate, document and manage patients' care. Staff were fully trained in how to use the system and told us that it worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future use or reference.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how consent should be recorded.

Staff we spoke with gave examples of how a patient's best interests were taken into account if they did not have the capacity to make a decision. Mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support.

Although formal training in the Mental Capacity Act 2005 had not been undertaken, staff were able to demonstrate their awareness and gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. Nurses demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff.

Health promotion and prevention

There was a process for informing patients who needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us they were contacted by the practice to attend routine checks and follow-up appointments.

We saw a range of information leaflets and posters in the waiting area for patients, informing them about services the practice offered and promoting healthy lifestyles, for example, smoking cessation, weight loss and fitness programmes. Information about how to access other health care services was also displayed to help patients access the services they needed, for example, carer support services, dementia and memory support groups, and sexual health.

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, cervical smear screening and general health checks including weight and blood pressure monitoring. We spoke with nursing staff who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes,

Good

Are services effective?

(for example, treatment is effective)

asthma, epilepsy and coronary heart disease. All new patients who registered with the practice were offered a consultation with one of the nurses to assess their health care needs and identify any concerns or risk factors that were referred to the GPs.

The practice had systems to identify patients who required additional care and treatments and were pro-active in offering services for specific patient groups. For example, vaccination clinics were promoted and held at the practice, including a seasonal influenza vaccination for older people. The most recent practice data showed that 57% of patients with long-term conditions had also received a seasonal influenza vaccination, compared to 52% nationally. NHS health checks were offered to patients aged between 40 and 74 using national guidance. These checks were used to identify health issues that required follow-up or further investigation by the GPs. Recent data indicated that the practice had achieved the highest number of health checks for this patient age group in the local area.

The practice kept a register of patients who had a learning disability and a GP took a lead role in promoting and encouraging annual health checks for these patients.

The practice offered a full range of immunisations for children and travel vaccines. Last year's performance for childhood immunisations was either in line or above average for the CCG area. For example, 93% of children aged 24 months had received the MMR vaccination, compared to the local average of 90%.

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 for 2013/14, and patient satisfaction questionnaires sent out by the practice in 2014. The evidence showed that patients were satisfied with how they were treated, that the practice staff were caring, compassionate and understanding. 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 also above average for its satisfaction scores on consultations with nurses, with 96% of respondents saying the nurse was good at listening to them and 96% also saying the nurse gave them enough time. Similarly, the results from the practice survey also showed that overall, respondents were very satisfied with the practice and many positive comments were noted.

Patients completed CQC comment cards prior to our inspection, to tell us what they thought about the practice. We received 34 completed cards containing very positive comments, with only one comment that was less positive. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected at all times.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consultation 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.

The practice had a confidentiality policy, which detailed how staff protected patients' confidentiality and personal information. The policy had been shared with staff, who had signed confidentiality agreements. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and gave examples of how they protected patient information. The reception area was designed in a way to help maintain confidentiality when staff were speaking on the telephone.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed there had been a positive response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 91% of respondents said GPs were good or very good in involving them in decisions about their care, compared to the national average of 82%. Similarly, 89% of respondents said nurses were good or very good at involving them in decisions, compared to 85% nationally.

When we spoke with patients, they told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options and that they felt included in their consultations. They felt able to ask questions and never felt rushed. One patient told us the GP always asked them if there was anything else they wished to discuss before they left their consulting room.

Patient/carer support to cope emotionally with care and treatment

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the help they needed and that they felt able to discuss any concerns or worries they had.

We saw that patient information leaflets, posters and notices were displayed that provided contact details for specialist groups that offered emotional and confidential support to patients and carers. For example, a counselling support group, as well as counselling sessions that were offered at the practice. The practice's electronic system alerted GPs if a patient was also a carer. We saw a range of information available for carers to ensure they understood the various avenues of support available to them.

The practice had developed a service for older patients over the age of 75, who were supported by a 'care co-ordinator' from the practice. Posters advertising the

Good

Are services caring?

service had been produced for patient information and the care co-ordinator had also conducted a patient survey to request feedback about the enhanced service. The results showed that the majority of patients felt they had benefited significantly from the service, had been reassured that their care was being monitored and organised for them, and that they found the practice innovative and caring in its approach.

Staff told us that if a patient had suffered bereavement, this would be noted on their records and a member of staff would contact them to offer support and advice. The practice website also offered bereavement advice and sign-posted patients to other help and support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs. The staff we spoke with explained that a range of services were available to support and meet the needs of different patient groups and that there were systems to identify patients' needs and refer them to other services and support if required. The practice had a larger population of older patients than the national average and had responded to these local needs. For example,

The practice engaged with the clinical commissioning group (CCG) and a GP from the practice had links with the CCG and attended meetings on a regular basis to review and discuss local pathways of care. The practice was therefore kept aware of service requirements and was able to plan and develop services that reflected the needs of the local patient population.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The patient participation group (PPG) had recently formed and future meetings were planned. However, the practice had acted on the results of a previous patient survey, where feedback had indicated that there were sometimes difficulties in getting through to the practice on the telephone to make appointments. As a result, an additional member of staff had been placed on reception to help ensure more calls could be taken from patients.

Tackling inequity and promoting equality

The practice was located in purpose-built premises that met the needs of patients with disabilities. There was level access to the treatment and consultation rooms that were all located on the ground floor. The waiting area was large enough to accommodate patients with wheelchairs and prams and accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had a hearing loop system for patients who had hearing difficulties and interpretation services were available by arrangement for patients who did not speak English. There were car parking facilities with disabled parking areas close to the building.

The practice took account of the needs of different patients in promoting equality and considered those who may be in vulnerable circumstances, for example, the homeless and travellers, who were able to attend and register at the practice as temporary patients if preferred. Staff had received equality and diversity training and were able to demonstrate an awareness of the needs of different patient groups. For example, identifying those patients with learning disabilities to help ensure they received appropriate care and support, including an annual assessment of their health care needs.

Access to the service

Appointments were available from 8.00am to 6.30pm each week day and the practice operated extended opening hours from 7.30am on Tuesday mornings and until 7.30pm on Tuesday evenings. The practice offered Saturday morning clinics and telephone consultations, available for older people and their carers to attend. These were also available for working patients, providing flexibility outside of core working hours and school hours for children. Data from the most recent national patient survey showed that 95% of respondents said that they were very satisfied or fairly satisfied with the practice opening hours, compared to 80% nationally.

The practice's patient list had grown significantly in recent years and in response to this, the practice had reviewed and adjusted its appointment system to maximise and improve access to GP appointments to help meet demands. Twice weekly 'walk-in' clinics had been introduced, where patients attended without the need to make appointments and was managed by two GPs for each morning session. The practice considered that these flexible arrangements had contributed to the reduction in attendances at accident and emergency (A & E) departments at the hospital and recent data showed that the practice had one of the lowest A & E attendances within the local CCG area. One patient we spoke with described an occasion when they had injured their hand and had attended the walk-in session at the practice, rather than go to the hospital A & E department.

Patients could book an appointment by telephone, online or in person. All of the patients we spoke with said that the appointments system worked well. They said they could have telephone consultations and that the GPs were very good at calling them back if requested. The GPs we spoke with confirmed that same day telephone consultations were offered to all patients and this was managed via the

Good

Are services responsive to people's needs?

(for example, to feedback?)

electronic communication system. Pre-bookable appointments were also available and home visits were arranged for those who found it difficult to attend the practice.

Patients we spoke with all expressed confidence that urgent problems or medical emergencies would be dealt with promptly, that staff knew how to prioritise appointments for them and that they would be seen the same day. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment. For example, the practice had a system to identify and prioritise patients at risk of unplanned hospital admissions to help ensure they had urgent access to a GP appointment.

Patients told us they could always request longer appointments if they needed them, particularly if they had long-term conditions or complex health care needs.

There were arrangements to ensure patients could access urgent or emergency treatment when the practice was closed. Information about the 'out of hours' service was displayed inside and outside the practice and was also included in the patient information booklet and on the practice website. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. There was a complaints policy that was in line with NHS guidance for GPs and 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. The procedure was included in the practice information booklet, on the practice website, and was displayed in the patient waiting / reception area. There was also a suggestion box and questionnaires for patients' to complete to provide comments and feedback to the practice. We looked at two complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way and in accordance with the practice policy.

A summary report for the previous year had been produced and identified some changes that had been made as a result of complaints received. For example, raising awareness to the importance of checking patient details accurately when transcribing information and following practice procedures at all times.

Patients we spoke with told us that they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to do so.

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 philosophy and statement of purpose, both of which reflected its aims in providing high quality person centred medical care, where patients always came first. Although the practice did not have a written 'vision' statement to inform individual or team objectives, when speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose of providing good quality care to all patients, in a safe environment, where they would be treated at all times with dignity and respect.

Governance arrangements

The practice had a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding vulnerable adults and a lead nurse for safeguarding children and infection control. A GP also took a lead role in dementia and had a special interest in services for older people. We spoke with ten members of staff who were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns or issues.

The practice had a structured programme of meetings, including weekly clinical and governance / practice meetings that included discussions about significant events, medicines management, staff training and recruitment. Information and analysis of the Quality and Outcomes Framework (QOF) was reviewed, to enable the practice to monitor on-going performance. We saw QOF data that indicated the practice was performing above the local and national standards in many areas and overall, data showed that the practice achievement had improved from 83% to 98% in 2013/14. The practice also held bi-weekly care co-ordination meetings and monthly multi-disciplinary meetings with other care providers and specialists, for example, social services and the palliative care team. There were monthly team meetings for all staff to attend, where in-house training and development was also undertaken, for example, e-learning activity.

The practice had to some extent, undertaken clinical audits to monitor quality and systems to identify where action should be taken to improve outcomes for patients, although these had been undertaken by medical graduates within the practice. For example, an audit had been undertaken to review medicine prescribing for patients who were taking combination medicines. However, follow-up audits had not been undertaken to conclude the outcomes, although these were planned in the coming year.

The practice had a number of policies and procedures to govern activity and these were available to staff on any computer within the practice and were also kept in hard copy files for staff guidance and reference. We looked at twelve of these and saw that they had been reviewed annually and were up to date.

The practice had arrangements for recording and managing routine risks in relation to the premises and its staff. Monthly checks were undertaken and risks identified, recorded and kept in a risk folder, and all staff were made aware of the issues raised. Risk assessments had been undertaken, for example, a fire risk assessment had been reviewed and updated.

Leadership, openness and transparency

We spoke with the practice GPs who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us they felt there was an 'open door' culture, the GPs were approachable, they felt supported and were able to approach the senior staff about any concerns they had. They said there was a good sense of team work within the practice and communication worked well. All staff said they felt their views and opinions were valued. They told us they were positively encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients.

The practice had a staff handbook containing a range of human resource policies and procedures. We reviewed a number of these, for example, bullying and harassment policies, which were provided to support staff. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards, complaints and questionnaires. The patient survey undertaken by the practice in 2014 had indicated that patients were satisfied with the services and care they received and the results had

Are services well-led?

Good

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

been mainly positive. Following the results of the survey the practice had developed an action plan to implement changes where less positive comments had been received. For example, a review of the appointments system to provide additional 'on the day' appointments and additional GP hours to cover the additional appointments offered.

The patient participation group (PPG) had recently become active and we spoke with a representative from the group, who told us they felt the practice had embraced the principles behind having a PPG. They said the practice GPs and staff had shown commitment in supporting and developing the group and future meetings were planned and dates confirmed. The next meeting agenda included a review of the most recent patient survey results to agree an action plan for the coming year, to identify where further improvements could be made.

The practice had gathered feedback from staff through discussions, appraisals and generally through staff meetings. All the staff we spoke with told us they had opportunities to comment and suggest ways of making improvements to the services. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Records showed that GPs and nursing staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. Staff said they had protected time set aside for learning and development, for example, monthly half-day closure of the practice to undertake training and development. One member of the administration staff team told us they had been supported to undertake a specific qualification in business administration.

Formal appraisals were undertaken to monitor and review performance, and to identify training requirements.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings to help ensure the practice considered safety, performance and improved outcomes for patients. For example, a recent significant event had resulted in a review of the investigation procedures for a specific condition.