St. Andrew's Medical Practice

Quality Report

St Andrew's Lane
Spennymoor
County Durham
DL16 6QA
Tel: 01388 817777
Website: standrewsmedicalpracticespennymoor.nhs.uk

Date of inspection visit: 28 June 2016
Date of publication: 28/11/2016

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 St Andrew's Medical Practice on 28 June 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed by staff who were experienced and well trained.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment in line with nationally accredited best practice.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- There was a focus on continuity of care with named GPs for patients with specific needs and 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. This included an active patient forum group that contributed to improvements in the practice.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw areas of outstanding practice relating to the responsiveness of the practice to patient need:

- A dedicated GP and nurse led a weekly drop-in service for teenagers. This was open to patients and those who were not registered with the practice but needed advice and support. This service provided targeted support to teenagers including with needs

Summary of findings

relating to sexual health and drug and alcohol use. Use of the drop-in service was well managed and staff liaised with community mental health and primary care services to ensure patients received the most appropriate support.

- The practice demonstrated a high rate of success in its approach to health improvement strategies. This included a 65% success rate in smoking cessation and a 2.6% reduction in teenage pregnancies.
- Special services were available for patients who self-harmed, or who were at risk of doing so. This included the availability of ad-hoc appointments with no notice, referrals to community psychiatric liaison teams and in-house counselling.
- The practice worked with a wellbeing health advisor who support patients with a learning disability, or other circumstances that meant they were vulnerable, to access health improvement services such as slimming or exercise groups or social support organisations.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared through well-structured clinical governance to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement, including in prescribing, medicines management and clinical assessment.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. This included training opportunities with specialist nurses to improve the range of services offered.
- The practice offered a minor injuries service to avoid unnecessary attendance at hospital A & E departments.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice highly for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the clinical commissioning group to secure improvements to services where these were identified. This included through clinical audits and engagement with medicines optimisation teams.
- There was dedicated provision for patients through a range of services. This included annual health checks and reviews for patients with a learning disability; a weekly drop-in baby clinic; a weekly drop-in teen clinic; a dedicated multidisciplinary diabetes service and regular 'ward rounds' in care homes by nurse practitioners. A physiotherapist, dietician, podiatrist and counsellors offering different types of therapy were available weekly in the practice and were provided by community services. This meant patients received care and support in line with their individual needs.
- Patients were able to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Ad-hoc or no-notice appointments were available for patients with specific needs or vulnerable circumstances, such as dementia.
- Online services were available including to make appointments, request prescriptions and view medical records.
- Evening and Saturday appointments were available weekly and a GP telephone triage service was available daily Monday to Friday.
- 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. Learning from complaints was shared with staff and other stakeholders and the practice worked closely with NHS England when needed to resolve complaints.

Are services well-led?

Good

The practice is rated as good for being well-led.

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. There was an active patients forum, which acted as a patient participation group.
- There was a strong focus on continuous learning and improvement at all levels, including structured succession planning to address staff retirements.

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.

- The practice offered proactive, responsive and personalised care to meet the needs of the older people in its population. This included participation in the avoiding unplanned admissions enhanced service, which provided older patients with additional care and support. For example, patients in this group had a direct line to the practice manager to arrange home visits or urgent appointments.
- The practice offered flu vaccinations, pneumococcal immunisations and shingles vaccines to all patients over the age of 65, which could be administered at home. Two annual open-access flu vaccination days were held and staff conducted opportunistic blood pressure and pulse checks with each patient.
- The practice adhered to the national Gold Standards Framework when working with palliative care teams to provide end of life care and treatment.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed, for example for insulin initiation for patients with diabetes.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. For example, one GP was the area lead for atrial fibrillation and heart failure and offered collaborative monitoring and treatment with a heart failure specialist nurse.
- A multidisciplinary diabetic clinic included care provided by a dietician, podiatrist, GP and nurse. Nurses and healthcare

Summary of findings

assistants were trained in foot pulse checks and could offer these as part of domiciliary visits. Patients newly diagnosed with diabetes were referred to an appropriate targeted education programme.
- The practice offered an anti-coagulation clinic to monitor warfarin administration. Patients who attended this had blood tests and dosing reviews completed in the same appointment.

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.
- Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- A weekly drop-in clinic was offered for teenagers who could attend for advice on any issue, including sexual health, contraception, eating disorders, smoking cessation, anxiety and acne. This was the only such clinic in the area and was led by a nurse practitioner with support from a GP. A GP also offered a service for this group to support with instances of self-harm. This included case tracking, follow-up appointments and liaison with local authority crisis teams.
- A GP and practice nurse operated weekly open access baby clinics that included immunisations and developmental checks as well as the chance to spend time with health visitors.
- The nursing team offered a range of sexual health services including fitting of intrauterine contraceptive devices, cervical smears and chlamydia testing and vaccination for the human papilloma virus.
- A dedicated carer's support worker was in place who proactively scheduled carers to undergo annual health checks and to receive the flu vaccination.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive 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).

Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services including to book appointments, request prescriptions and to access medical records. A range of health promotion and screening was available that reflected the needs of this age group.
- Appointments were available one evening per week and on Saturday mornings to enable people to attend outside of working hours.
- A physiotherapist was available on site weekly that reduced the need for patients to be referred externally.
- A fortnightly drop-in support service was offered by the Citizens Advice Bureau to provide patients with advice on financial matters and issues relating to disability.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Such patients were offered an annual health check by a nurse and GP involving blood tests, echocardiogram, blood pressure checks and a cervical smear where necessary. A GP provided a mental health assessment to help meet the patient's social care needs.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. For example, school nurses and health visitors regularly held training sessions with the whole practice team on child protection and safeguarding.
- The practice informed 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.
- The practice worked with a wellbeing health advisor who provided support to patients in establishing health improvement plans, such as joining a slimming group or accessing social support.

Summary of findings

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.
- 87% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was better than the clinical commissioning group average of 83% and the national average of 84%.
- The practice carried out advance care planning for patients with dementia. All patients were included in the unplanned admissions service, had a care plan in place, a named GP and direct access to appointments and home visits through the practice manager.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. For example, annual health checks were offered that included an assessment of physical and mental health, such as smoking cessation advice, alcohol consumption reviews, dietary advice and medication monitoring.
- On-site counsellors offered a range of therapies including cognitive behaviour therapy, mindfulness and 'Talking Changes' therapy through the Improving Access to Psychological Therapies (IAPT) scheme.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 252 survey forms were distributed and 113 were returned. This represented 1% of the practice's patient list.

- 77% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 79% and the national average of 73%.
- 79% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 77% and the national average of 76%.
- 88% of patients described the overall experience of this GP practice as good compared to the CCG average of 90% and the national average of 85%.
- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 84% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards, nine of which were positive about the standard of care received, particularly in relation to the individualised care provided by clinical staff and the approach of receptionists in making appointments.

We spoke with six members of the patient forum group during the inspection. All members said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Outstanding practice

- A dedicated GP and nurse led a weekly drop-in service for teenagers. This was open to patients and those who were not registered with the practice but needed advice and support. This service provided targeted support to teenagers including with needs relating to sexual health and drug and alcohol use. Use of the drop-in service was well managed and staff liaised with community mental health and primary care services to ensure patients received the most appropriate support.
- The practice demonstrated a high rate of success in its approach to health improvement strategies. This included a 65% success rate in smoking cessation and a 2.6% reduction in teenage pregnancies.
- Special services were available for patients who self-harmed, or who were at risk of doing so. This included the availability of ad-hoc appointments with no notice, referrals to community psychiatric liaison teams and in-house counselling.
- The practice worked with a wellbeing health advisor who support patients with a learning disability, or other circumstances that meant they were vulnerable, to access health improvement services such as slimming or exercise groups or social support organisations.

St. Andrew's Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to St. Andrew's Medical Practice

St Andrew's Medical Practice is situated in a purpose-built building with full disabled access. There is an on-site dispensary staffed by two dispensers Monday to Friday and an on-site private pharmacy. The practice clinical team is led by six GP partners and has one salaried GP, two practice nurses, two nurse practitioners and three healthcare assistants. This is a teaching practice and has up to two foundation level doctors at the same time. Locum doctors are used to cover absence of permanent staff only. A practice manager is in post and leads a non-clinical team consisting of an administration manager, administration supervisor, eight receptionists, two secretaries and three housekeepers.

A private room is available adjacent to the reception desk, which patients can use to request a confidential discuss with staff.

A range of additional clinical staff are available throughout the week, including a physiotherapist, dietician, podiatrist and counsellors.

The practice serves a patient list of 10,535 people and is in an area of high levels of deprivation.

Appointments are from 8.30am to 1pm and 2pm to 7.30pm on Mondays, from 8.30am and 1pm and 2pm to 6pm Tuesday to Friday. Appointments are available on Saturday mornings from 8am to 12pm.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 June 2016.

During our visit we:

- Spoke with a range of staff and spoke with members of the patient forum group.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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 looked 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).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- The practice manager was the lead member of staff for incidents, which staff reported using an electronic system. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. All of the staff we spoke with said they felt confident and supported to submit incidents as part of a 'no blame' culture of working.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a root cause analysis of each incident and significant event, which was reviewed by the practice manager and GPs on a quarterly basis. They were also discussed in bi-monthly staff meetings with the whole practice team. An annual review of all incidents took place that was used to identify trends and changes in practice or policy that could reduce risk.
- In the 12 months prior to our inspection, 48 incidents or near misses were documented. Nine of these were attributed to causes outside of the practice, such as pathology or pharmacy errors. The remaining 39 incidents were analysed for trends and avoidable mistakes. For example, administration staff ensured patient identity was confirmed with date of birth and NHS number before sending out referrals and letters and new checks were implemented on repeat prescriptions to reduce the risk of contraindicated medication being administered.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. 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. There was a lead member of staff for safeguarding. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies, including proactive liaison with local authority crisis teams and the police.
- Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3.
- A notice in each clinical room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. 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 was no chaperone notice in the waiting rooms. We spoke with the practice manager about this who said they would put up notices in these areas.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. A healthcare assistant undertook infection control audits and we saw evidence that action was taken to address any improvements identified as a result, such as new guidance around the correct and safe use of sharps bins.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe, including in obtaining, prescribing,

recording, handling, storing, security and disposal. Monthly medicines audits and medicines management meetings took place to monitor the quality of the processes in place.

- A medicines optimisation pharmacist visited the practice every two weeks to monitor prescribing and the dispensary and to provide support in the management of controlled drugs.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines. The latest antibiotic audit cycle completed in February 2016 and showed 71% compliance with documentation. A re-audit was due to be completed in July 2016.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Two nurses were qualified independent prescribers, including one to degree level. They could prescribe medicines for specific clinical conditions and received mentorship and support from medical staff and pharmacy teams for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process; which are written instructions about how to safely dispense medicines.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy in place and emergency equipment for use in an evacuation, including an evacuation slide so people with reduced mobility could quickly leave the first floor. The practice had up to date fire risk assessments and carried out regular fire drills.
- Two members of staff had been trained as fire marshals and there was always a fire marshal on duty when the building was open to the public. A simulated evacuation had taken place and learning implemented from this, including the need for staff to sign out of the building when they leave.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice 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. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency and panic alarms were in situ at the main reception desk.

Good

Are services safe?

- Staff received life support and cardiopulmonary resuscitation (CPR) training in line with their role and responsibilities. All of the nurses and six out of seven GPs had advanced CPR training. In addition, all non-clinical staff had basic life support and CPR training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit, emergency medicines and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Staff had updated and refined the business continuity plan after a major incident in the practice's previous premises. This meant they were well practised in responding to situations that may interrupt the service or present a risk to patients, staff and visitors.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Staff used national best practice guidelines to provide care and treatment, including the Gold Standards Framework for palliative care.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results were 99% of the total number of points available. Exception reporting was significantly lower than the national average in the osteoporosis and primary prevention of cardiovascular disease clinical domains. Exception reporting was significantly higher than the national average in three clinical domains; cancer, chronic obstructive pulmonary disease and rheumatoid arthritis. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2014 to March 2015 showed:

- Performance for diabetes related indicators was better than the national average in all five indicators. For example, 96% of patients with diabetes had a flu vaccination compared to the national average of 94% and 91% of patients with diabetes had an acceptable level of cholesterol recorded in the previous 12 months, compared to the national average of 81%.
- Performance for mental health related indicators was better than the national average in two out of three indicators and worse than the national average in one indicator. For example, 95% of patients with schizophrenia, bipolar affective disorder or another psychosis had their alcohol consumption recorded in the previous 12 months, compared with the national average of 90%. 79% of patients with dementia had a face to face review in the previous 12 months compared to the national average of 88%.

There was evidence of quality improvement including clinical audit:

- There had been six clinical audits completed in the last 12 months. One of these was a complete 'two-cycle' audit with data supplied according to all four stages of the audit process. In five other audits there was missing data from the reaudit or insufficient detail to fully meet all stages of the auditing requirements. However, there was evidence of improvement in practice from audits. For example, an audit of stroke risk and the use of anticoagulants in patients with atrial fibrillation led to improved assessment and advice from clinical staff and the use of novel oral anticoagulants in patients who were not suitable for Warfarin, which was the standard treatment.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, a recent audit of patient signposting had been undertaken. This looked at whether signposting to community organisations or social care services had been timely, appropriate and useful. The results of the audit were used to help guide staff to make appropriate signposting decisions.
- The teen clinic had been successful in contributing to a 2.6% reduction in teenage pregnancies in the local area through its sexual health screening, contraception and advice services.
- The practice achieved a 65% successful quit rate in its smoking cessation service.

Good

Are services effective?

(for example, treatment is effective)

- Staff established failsafe recall systems for patient results. This meant that all patients received a timely recall to attend an appointment, for example after a colposcopy.
- The practice tracked the uptake of vaccinations and used these data to research the impact of the vaccinations, such as the human papilloma virus vaccine.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. This ensured patients were cared for and supported by a highly qualified, competent team of staff that were able to direct their own professional development and learning portfolios.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The programme was tailored to individual staff roles and needs. For example, the induction programme for foundation doctors included a structured approach to helping them understand the specific needs of the local population, including the provision of therapeutic support, a dedicated teenage pregnancy care pathway and 'social diagnosis' programme that helped staff to consider the holistic needs of each patient.
- The practice could demonstrate how they ensured role-specific training and updating for clinical staff. For example, for those reviewing patients with long-term conditions and care such as sexual health services, travel immunisations and 24 hour echocardiogram and blood pressure monitoring. Clinical staff had recently undertaken training from a respiratory nurse specialist in the management of patients with chronic obstructive pulmonary disease and nurses were trained in spirometry.
- Non-clinical staff had a range of training and qualifications to match their role that enabled them to provide a high standard of practice support to colleagues and patients. For example, staff were qualified in areas such as employment law, customer service and British Sign Language.
- Staff sought out accredited training wherever possible to ensure their work was benchmarked by national best practice guidance. This included practice management training accredited by AMSPAR (The Association of Medical Secretaries, Practice Managers, Administrators and Receptionists) and immunisation training accredited by MASTA (Medical Advisory Service for Travellers Abroad).
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Appraisals were led by each individual member of staff as a reflective exercise supported by their manager to help identify developmental needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff worked within a number of multidisciplinary clinical teams to provide specialist care, including a heart failure specialist nurse, counsellors, a dietician and a respiratory nurse specialist.

Good

Are services effective?

(for example, treatment is effective)

- A physiotherapist and counsellors were available on-site on a weekly basis, which reduced the need for patients to be referred externally. This also meant patients could be seen more quickly.
- The practice manager reviewed patient attendances at accident and emergency (A & E) departments to see if they could have been more appropriately treated elsewhere, such as in the practice or at a pharmacy or urgent care centre. The review process was also used to ensure vulnerable patients were followed up appropriately. We saw evidence this system was effect at protecting people from avoidable harm or deterioration. For example, when a patient who was at risk of self-neglect left an A & E department without being seen, a GP followed up with them immediately. In addition, where a young patient was known to self-harm and had been seen at an A & E department, their named GP contacted them to arrange an appointment to talk about the incident.
- The practice liaised with appropriate agencies to ensure patients received appropriate care when they were seen unexpectedly at hospital. This information was shared with out of hours GP services, district nurses and Macmillan nurses as needed.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance and legislation.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Healthcare assistants were proactive in signposting patients to relevant services, including to a local wellbeing team that provided access to a range of programmes such as healthy eating, practical cooking and weight loss.
- A dietician and podiatrist was available as part of a multidisciplinary diabetes clinic.
- Staff proactively referred patients newly diagnosed with diabetes to an appropriate nationally-recognised education programme, such as DESMOND (Diabetes Education and Self Management for Ongoing and Diagnosed) or DAFNE (Dose Adjustment for Normal Eating). This helped to empower patients to manage their diet and lifestyle in a way that promoted healthy living with diabetes.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 78% and better than the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For

Good

Are services effective?

(for example, treatment is effective)

example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 97% to 99% (except for meningitis C) and five year olds from 96% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Senior staff ensured new applicants to work in the practice had the ability to show empathy to anxious and distressed patients and relatives through the use of an interview scoring tool. This ensured the practice team worked well together to facilitate a caring, compassionate environment.
- The practice received 12 formal compliments between March 2016 and June 2016 in which patients mentioned their satisfaction with service from GPs, nurses, healthcare assistants and receptionists.

We spoke with six members of the patient forum group (PFG). 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.

Nine of the 11 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two patients commented on an inconsistent approach from staff, including the friendliness of reception staff and the timeliness of prescriptions and call backs from doctors.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice performed comparably with clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 95% and the national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients commented they felt involved in decision making about the care and treatment they received. They also said they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.

Good

Are services caring?

- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- 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.
- A member of the non-clinical team was qualified to level two in British Sign Language and could accompany patients to appointments as a chaperone.
- Information leaflets were available in easy read format and posters on display that represented the needs of the local population, such as signposting domestic violence services.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. Written information was available to direct carers to the various avenues of support available to them and staff proactively offered them an annual health check.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered evening appointments on a Monday and Saturday morning appointments for working patients or students who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability. Patients were proactively offered an annual health check by a GP and nurse that included blood tests, blood pressure checks, and an echocardiogram and cervical smear where appropriate. A GP also offered a mental health assessment where the patient had social care needs. The practice worked with a wellbeing health advisor who support patients with a learning disability, or other circumstances that meant they were vulnerable, to access health improvement services such as slimming or exercise groups or social support organisations.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. This included patients with dementia, who were given direct access to appointments and home visits through the practice manager.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations administered by an accredited member of staff. Baby and childhood immunisations were available as well as nurse-led immunisations for meningitis, measles (MMR) and the human papilloma virus (HPV).
- There were disabled facilities, a hearing loop and translation services available. Reception staff demonstrated initiative and proactiveness in supporting patients in non-clinical communication by helping them to communicate using online translation software. One member of staff was qualified in British Sign Language and supported patients accordingly, including as a chaperone when needed.
- A range of services were available for patients with diabetes. This included insulin initiation and foot pulse checks as well as access to a multidisciplinary diabetic clinic run by a GP, nurse, dietician and podiatrist.
- A GP was the area lead for atrial fibrillation and heart failure and provided opportunistic screening for atrial fibrillation. Staff provided collaborative treatment with a heart failure specialist nurse.
- A GP and nurse practitioner ran a weekly drop-in service for teenagers. This meant teenagers could attend without an appointment to discuss any problem or issue that was worrying them. Sexual health screening was available and patients could be referred for counselling or support for other concerns such as drug use or smoking cessation. Staff who ran this clinic had training in the Gillick principles of consent and had undertaken training in HIV testing with a clinical specialist in this area.
- A GP and practice nurses offered a weekly open-access baby clinic that included an immunisation programme and developmental checks with a health visitor.
- A fortnightly drop-in support service was offered on-site by the Citizens Advice Bureau. This enabled patients to be seen without an appointment for support on issues such as personal finances, housing benefits and disability support organisations.
- On-site counsellors offered a range of therapies including cognitive behaviour therapy, mindfulness and 'Talking Changes' therapy through the Improving Access to Psychological Therapies (IAPT) scheme. This enabled patients to access services more quickly than could be achieved through external referrals.
- The practice recognised a relatively high incidence rate of self-harm amongst young people in the local population. To address their needs a named GP proactively monitored the patients, including follow-ups and liaison with the local authority crisis team. In the previous two quarters, eight patients in their teens and 20s had accessed this service. The lead GP liaised with community mental health teams and community psychiatric services to provide multidisciplinary, targeted support. The self-harm service was available to any patient regardless of age and the service had seen 14 patients above the age of 30 in the same period, with appropriate support and mental health or urgent referrals put in place.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Nurse practitioners conducted regular 'ward rounds' of all registered patients in three local care homes. This included a review of prescriptions, care plans and a follow-up after hospital attendances.

Access to the service

Appointments are from 8.30am to 1pm and 2pm to 7.30pm on Mondays, from 8.30am and 1pm and 2pm to 6pm Tuesday to Friday. Appointments are available on Saturday mornings from 8am to 12pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. A GP triage service was offered three hours per day, Monday to Friday. This service enabled patients to have a telephone consultation during which the GP would decide on the best course of action to take for their medical concern. This helped patients to access advice more rapidly without the need to wait for an appointment. Dedicated appointments for minor injuries and minor illnesses were available daily and clinical staff always saw children, those with dementia and those at risk of elf-harm on demand.

The dispensary was open from 9am to 1pm and 4pm to 6pm Monday to Friday.

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.

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 83% and the national average of 78%.
- 77% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and the national average of 73%.

To help reduce wasted appointments through patients not attending when scheduled, the practice sent a text message reminder to each patient prior to their visit. The practice manager tracked instances of missed appointments and contacted patients to discuss this as a preventative measure when four consecutive appointments had been missed.

The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. Staff also scheduled appointments with the needs of patient groups in mind. For example, children with asthma were offered an annual review during the school holidays to reduce disruption to them. Nurses also offered late clinics on a weekly basis for patients who could only attend after work or school.

The practice participated in an unplanned admissions service for patients with dementia and those experiencing poor mental health. This meant the practice used regular healthchecks and access to urgent appointments to help reduce the need for hospital admissions.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- 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, including in the waiting areas, on the website and in the patient information leaflet.

We looked at five complaints received in the first quarter of 2016 and found them to be investigated and resolved appropriately. In all cases the practice acknowledged patients immediately and explained the outcome of the complaint following an investigation. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, GPs improved their communication with patients about changes to repeat prescriptions, such as when a medicine was no longer needed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement, which staff had contributed to and said they felt part of.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- Plans were in place for a community psychiatric nurse to be based in the practice regularly to provide mental health link support.
- Uptake of the electronic prescriptions service had been relatively low, with only 4% of patients making use of this. The practice manager worked with the patient forum group to make this service more accessible on the practice website with a particular focus on encouraging young people and those in full time work to take it up.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintainedby the practice manager, administration manager and GP partners.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- A series of meetings ensured the clinical governance structure worked well in practice, including a bi-monthly GP partner meeting. Nurses and healthcare assistants met every six weeks to discuss clinical practice, incidents and any issues within their respective teams. This meeting was used to share learning and best practice. GPs and nurse prescribers attended monthly medicine management meetings as part of the clinical governance structure for medicines.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff at all levels of the practice told us they felt respected and valued by the senior team.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Good

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient forum group (PFG) and through surveys and complaints received. The PFG met each quarter, carried out patient surveys and submitted proposals for improvements to the practice management team, which were considered and acted on where possible. For example, a member of the PFG redesigned the practice website following feedback on how it could be improved. This included a direct link to the GP survey to encourage more patients to take part.
- The PFG had asked for a broader range of staff to be present at quarterly meetings, which had been acted on. For example, a GP began to attend in addition to the practice manager. Guest speakers attended meetings to help members of the PFG contribute to multidisciplinary working practices, including a pharmacist and a speaker from the Alzheimer's Society.
- The practice produced a quarterly newsletter that helped to engage patients. This was available in the waiting room and on the practice website and included details of any changes to opening hours, such as over holidays, details of topical health drives such as flu vaccines and results from surveys. The newsletter was also used to encourage patients to join the patient group forum.
- The practice gathered feedback from staff through regular meetings and annual appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

The practice manager led a succession planning programme to ensure the practice remained in a strong position to meet the needs of the local population despite the planned retirement of long-standing staff.