Dr Miles Davidson

Quality Report

Stubley Medical Centre
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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?	Requires improvement
Are services effective?	Outstanding
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 Stubley Medical Centre (Dr Miles Davidson) on 14 October 2015. Overall the practice is rated as good.

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

- The practice had excellent purpose-built facilities and was well-equipped to treat patients and meet their needs
- The practice had been one of the lowest users of the out of hours' service within the CCG over the last three years, and hospital admissions were also amongst the lowest despite the demographics of their patient profile (higher number of older patients and higher disease prevalence rates)
- Patients said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- There was a clear leadership structure and staff felt supported by management. There was evidence that staff worked together well as a team and proactively engaged with the wider multi-disciplinary team to improve patient care.
- 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. Staff were supported to develop their skills and knowledge.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, there was not a consistent approach in how incidents were reported, although learning points were shared with the wider practice team .
- Risks to patients were generally assessed and well managed, with the exception of those relating to recruitment checks.
- Data showed patient outcomes were generally above average for the locality.
- The practice held regular meetings but these were not always documented to reflect discussions and demonstrate outcomes.

Summary of findings

- Urgent appointments were available on the day they were requested. However, patients told us that they sometimes had to wait a long time for non-urgent appointments.
- Information on making a complaint was not readily available, and verbal complaints were not always reviewed. However, we did see evidence that learning had been applied from written complaints.

We saw two areas of outstanding practice:

- The practice had a designated champion for frail and older people. The role ensured patients could access help and care rapidly to meet their needs, allowing them to remain in their own home. This was achieved via a co-ordinated multi-disciplinary approach focussed upon a holistic and caring patient-centred approach.
- The proactive approach to more complex patients had reduced the number of hospital admissions and A&E attendances. The practice also had the lowest rate of emergency admissions for patients experiencing poor mental health.

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

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all employment checks required by law for all staff.
- Ensure that a Disclosure and Barring Service check has been completed for all clinical staff and any non-clinical staff acting as chaperones.

In addition the provider should:

- Improve the availability of non-urgent appointments.
- Review the systems for complaints by making information on complaints more easily accessible to patients. Ensure that all verbal complaints are recorded.
- Implement one approach to the recording of significant events by the use of a specified template.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However the way of recording incidents was not consistent and these were not reviewed collectively by the practice team to identify any recurrent themes and consider wider learning

Risks to patients were generally assessed and well managed. However, not all clinical staff or other staff undertaking chaperone duties had an appropriate Disclosure and Barring check completed. There was no risk assessment in place to consider whether this would be appropriate or to indicate how any risks would be managed. Pre-employment checks and documents were not all present in staff files in line with legal requirements.

Systems to safeguard children and adults were in place.

The practice had effective systems in place to manage infection control, medicines management and dealing with medical and site-related emergencies.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Data showed patient outcomes were generally above average for the locality. The practice had achieved 99.5% in the Quality and Outcomes Framework (QOF) for 2013-14. QOF data showed that outcomes for patients were good for conditions such as rheumatoid arthritis, osteoporosis and coronary heart disease. The practice had achieved 100% of the available points in all of these areas which was above both the CCG and national averages.

Staff had access to National Institute for Health and Care Excellence (NICE) and local guidance and patient pathways of care. There was a process for keeping updated on new and revised guidance.

The practice could demonstrate the effectiveness of its work by the low use of Accident and Emergency (A&E) and the out of hours' service. Figures for 2014-15, showed that out of hours' practice contacts were 141 per 1000 population, compared to the CCG figure of 214.

Emergency hospital admission data over a three year period for patients aged over 65 showed the practice to consistently have one of the lowest percentages in the CCG despite the fact that it has a

Summary of findings

higher number of patients in this age group with accompanying high disease prevalence. Due to the expertise developed in mental health, the practice had the joint lowest rate of adult mental health emergency admissions in the CCG. Data observed over the last three years demonstrated that this was an ongoing achievement.

The role of the champion for frail and older patients ensured that those identified at risk had access to rapid support from the practice and a range of community and voluntary services. There was evidence to support this role had helped reduced emergency hospital admissions and attendance at out of hours' services.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. GPs had lead areas of responsibility such as prescribing, and provided support and advice to the rest of the team. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff, and these were aligned to practice objectives. Staff routinely worked with multidisciplinary teams including pharmacy and the district nursing and health visiting teams to enhance patient care and outcomes. There was evidence of completed clinical audit cycles and these were used to improve outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services.

We observed a patient-centred culture. The practice team were motivated and inspired to offer kind and compassionate care. We found many positive examples to demonstrate how patient's valued the care given by the practice. For example, the last GP survey results showed that 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 90%.

There was a proactive approach to the identification of carers and directing them to sources of support. Bereaved relatives were supported and a representative of the practice tried to attend the funeral when a patient had died.

Patients and representatives of the Patient Participation Group we spoke with valued the support given by the practice team and felt that patients received high quality care. We spoke with staff from other services who unanimously told us that the practice offered a very caring and highly supportive approach with their patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice had excellent facilities and was well equipped to treat patients and meet their needs. It was fully accessible to patients with a disability and accommodated for the needs of all patient groups including a designated children's play area.

Some of the feedback received from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were available the same day. The practice had a triage system in place to identify those requiring an urgent consultation, but we observed that the average wait for a routine appointment was between two and three weeks. There were no extended hours' surgeries to accommodate those who may find it difficult to get to the practice during normal working hours.

Information about how to complain was available although this was not easily accessible. There were no complaints leaflets available and no information on the website regarding how to make a complaint. Verbal complaints were not always recorded. However, the practice responded in a timely and sensitive manner to complaints and there was evidence of learning from the written complaints that had been received.

Are services well-led?

Good

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

It had developed practice specific objectives and ensured that staff were aware of these by incorporating them into the annual appraisal process. Staff understood their responsibilities and worked as a team to achieve good outcomes. There was a clear leadership structure and staff told us that they were supported by management.

The practice had a number of policies and procedures to govern activity and held regular meetings. The meetings were not always documented to provide a record of discussions and highlight actions to be undertaken. There were systems in place to monitor and improve quality and identify risk but these had not always enabled the provider to identify assess and mitigate risk; for example in respect of having safe recruitment procedures.

There was an active patient participation group (PPG) which worked with the practice and helped with events such as the annual flu campaign. The PPG had influenced changes in the practice, for example, a review of incoming telephone calls leading to a re-design of the automated process thereby reducing telephone answering times. The practice had established good links with other local practices and worked well with them. Staff had received inductions and performance reviews, and regularly attended events organised by their CCG.

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 provider was rated as good for this population group.

The practice had 28.7% of their registered patients aged over 65 compared against a national average of 16.7%, and they had adapted their services to accommodate this need.

A practice nurse was designated as a champion for frail and elderly patients. The nurse chaired a fortnightly multi-disciplinary meeting to review at risk patients or those with complex needs. A dedicated telephone number was available for identified older patients to contact the nurse for advice and support. These patients were allocated an urgent appointment slot if they needed to see the GP.

The nurse visited the patients at home if they were unable to attend the surgery. Home visits were incorporated into the flu vaccination programme and this was used as an opportunity to review whether sufficient support services were in place to support that person in their home. Reception staff were able to identify any at risk patients who called the practice by an icon marked on their records, enabling responsive action to be taken promptly. This work contributed to the practice's avoidance of hospital admission work and we observed data that this targeted work had reduced emergency admissions. Hospital admissions including A&E attendances, routine day case appointments and acute stays between April–September 2014 was 180, and for the same period in 2015, this had reduced to 131.

Emergency hospital admission data over a three year period for patients aged over 65 showed the practice to consistently have one of the lowest percentages in the CCG despite the fact that it has a higher number of patients in this age group with accompanying high disease prevalence.

Care plans were under development with a target to provide a written plan for all over 75s with by the end of March 2016. An annual safety net audit was undertaken for patients over 75 to identify anyone who had not made contact with the practice so they could be followed up.

Referrals were made to other services when appropriate, such as the community falls service. Patients were also signposted to voluntary organisations including the Stroke Association and befriending services.

Summary of findings

A health care assistant (HCA) ran a wound management clinic and communicated with the tissue viability service when this was indicated. The HCA also contributed to the anti-coagulation service provided as part of an additional enhanced service, enabling patients taking Warfarin to be monitored by the practice.

Data showed that flu vaccination rates for patients over 65 at 80.06% exceeded the national average of 73.24%. The practice offered a range of enhanced services including end of life care and dementia.

People with long term conditions

Good

The provider was rated as good for this population group.

Due to the high numbers of older people registered at the practice, there was a high prevalence of patients with long term conditions. For example the prevalence of hypertension at 18.82% was 2.5% above the CCG average and 5.09% above the national average.

Patients at risk of hospital admission or those who had been recently discharged were identified as a priority and discussed as part of the fortnightly multi-disciplinary meeting. For those people with the most complex needs, a clinician worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Written care plans were established for all patients with a diagnosis of diabetes and those with severe chronic lung disease as part of the hospital admissions avoidance work. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met.

The practice had developed a joint care plan booklet for patients with type II diabetes. This listed appointment dates and allocated a specific annual review month. The plan gave basic information about diabetes and the common types of medication used. It also recorded the last recorded weight, blood pressure and HbA1c (an indication of blood sugar levels) including a target figure. Additionally, the plan signposted patients to websites and a self-help course. The booklet was retained by patients for reference.

Newly diagnosed patients with diabetes were referred into two half day externally facilitated programmes run by a dietician and a diabetes specialist nurse to educate them on managing their condition. Feedback received from patients had been very positive following their attendance.

Remote monitoring of hypertension was undertaken to enable self-management and prevent patients having to attend the practice unnecessarily. The patients submitted their blood pressure readings at agreed intervals for monitoring.

Summary of findings

Families, children and young people

Good

The practice was rated as good for families, children and young people.

The co-location of the health visiting team in the same building facilitated fast and regular communication on any issues relating to children living in disadvantaged circumstances. Evidence could not be provided to demonstrate that planned and documented meetings took place to review patients where safeguarding concerns had been highlighted. However, we were assured that effective liaison took place with others in order to safeguard children effectively, and this was confirmed in discussion with the health visitor.

Immunisation rates were high for all standard childhood immunisations. For example, immunisation rates for five year olds ranged from 98-100% which was slightly above the national average. Appointments were available outside of school hours. We spoke with the midwife during our visit who ran a weekly clinic at the practice and she told us that the GPs were always available for advice and support if needed.

The practice accounted for the needs of mothers and young children and had a designated play area for children with a television screen at low level showing children's programmes. Breast feeding facilities were available on site.

Information was displayed regarding how young carers could access support services.

Working age people (including those recently retired and students)

Good

The practice was rated as requires improvement for working age people (including those recently retired).

The services available did not fully reflect the needs of this group. The practice did not offer extended opening hours for appointments, and closed after 1pm on Wednesdays. Telephone appointments were available from 8.30am but no face to face consultations were available until 9am on four days of the week. Appointments were available at 8.30am one day/week and the practice planned to introduce this on a second day in the near future.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages. Some people we spoke to during the inspection, and some of the responses provided on comment

cards, stated patients found it difficult to get appointments when they needed them. For example, 53% patients said they felt they normally have to wait too long to be seen compared to the CCG average of 63% and a national average of 58%.

Patients could order repeat prescriptions online, and the practice was trying to encourage greater uptake of this service. Online appointments could be booked but this was limited to six appointments per GP available each week. Health promotion advice was offered and there was some health promotion material available through the practice. Patients could request any additional information to be printed out at reception.

People whose circumstances may make them vulnerable

Good

The practice was 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. It had carried out annual health checks for people with a learning disability and 78% of these patients had been seen so far this year. The remaining patients were proactively being followed up to encourage their attendance. The practice offered longer appointments for people with a learning disability. Patients who had been in hospital were contacted by telephone on their return home to check if they were managing sufficiently.

Patients who may be vulnerable were identified and followed up appropriately. For example, the nurse informed us about a frail patient with a diagnosis of dementia who attended the practice. A home visit was arranged to review any additional support they required and this was subsequently arranged to keep the patient safe within their own home.

The prevalence of cancer was high at 4.88% which was approximately 2.5% above the CCG and national average, and this was due to the numbers of older patients registered at the practice. Patients needing end of life care were discussed with the district nursing team and Macmillan nurses. Systems were in place to meet patient needs including special patient notes (which enable out of hours providers to obtain key information about the patient) and just-in-case boxes (anticipating symptom control needs and enabling the availability of key medications in the patient's home if required).

There were lower rates of emergency cancer admissions at 5.56 per 100 patients on the disease register compared to the expected value of 7.45, demonstrating the effectiveness of the approach taken with cancer patients.

Summary of findings

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

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for people experiencing mental health (including people with dementia).

The practice scored 100% QOF achievement on mental health indicators which was 2.3% above the CCG average and 9.6% above the national average.

83% of people experiencing poor mental health had received an annual physical health check, and the practice were attempting to engage with the outstanding patients to increase this figure. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Work was in progress to develop formal care plans for patients with dementia, although RightCare plans were in place to provide essential patient information for the out of hours' provider. The practice carried out advance care planning for patients with dementia, and staff understood the application of principles from the Mental Capacity Act.

Signposting information for carers of patients with a mental health problem was available. A support programme for patients with dementia and their carers was displayed in the reception area.

One GP was a qualified cognitive behavioural therapist and saw many of the patients with mental health difficulties, and acted as a resource for the rest of the team with regards any queries.

Due to the expertise developed in mental health, the practice had the joint lowest rate of adult mental health emergency admissions in the CCG. Data observed over the last three years demonstrated that this was an ongoing achievement. The practice also had a low referral rate to community mental health services and had low prescribing rates for anti-depressant and tranquiliser medications.

The practice had told patients experiencing poor mental health about how to access support groups and voluntary organisations. Patients were referred or could self-refer to talking therapies as part of the Improving Access to Psychological Therapies (IAPT)

programme for those with mild to moderate conditions including anxiety and depression which may occur due to their long standing health issues. Information on support services was available in the waiting area.

All staff had received training on dementia awareness in August 2014. All three GPs had attended mental health training in the last 18 months including topics on partnership working and prescribing for mental health problems.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. There were 126 responses which represented a 50% response rate of the sample practice population who received the survey.

The practice scored higher than average in terms of patient experience with regards to contacting the surgery by telephone, and also in respect of being treated with care and concern. For example:

- 83% of respondents find it easy to get through to this surgery by phone compared with a CCG average of 76% and a national average of 73%.
- 98% of respondents say the last nurse they saw or spoke to was good at treating them with care and concern compared with a CCG average of 93% and a national average of 90%
- 93% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care compared against a CCG average of 88% and a national average of 85%

The survey identified the practice could perform better in the following areas:

- 67% of respondents describe their experience of making an appointment as good compared with a CCG average of 76% and a national average of 73%
- 79% of respondents were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%
- 76% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care compared with a CCG average of 86% and a national average of 81%

We saw evidence that the practice had analysed the results of this survey and were reviewing how they could improve on the areas in which they received lower satisfaction scores. For example, they were considering increasing the number of bookable online appointments.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 114 comment cards of which 87% were very positive about the high standard of care received including being treated with kindness and respect. The triage system was well received by those who commented about the process. The negative comments related to difficulties in obtaining an appointment at the practice.

Dr Miles Davidson

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 adviser, a practice manager specialist adviser and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr Miles Davidson

Dr Miles Davidson's practice is situated within Stubley Medical Centre. The premises re-located to the modern purpose-built premises in Dronfield in 2009. It is well-equipped and built and furnished to a high specification. The practice is co-located with a range of community based services provided by Derbyshire Community Healthcare Service (DCHS) including the district nurse and health visitor teams. The practice is situated on the ground floor of the building and is fully compliant with Equality Act and anyone with a disability can access the services on site without difficulty.

It provides primary medical services to its 4,885 registered patients. It serves an area with generally high affluence and is ranked in the tenth least deprived decile. This would usually indicate a lower demand for health services; however there are a significantly higher proportion of older people on the patient list compared with other practices in England. For example, the practice has 28.7% patients aged 65-74, compared against a national average of 16.7%. As older patients have more complex needs, this increases the demand for health care. The majority of the patients are of white British background.

Dr Miles Davidson is the lead GP, and is supported by 2 part time salaried GPs (one male and one female). The practice has two part-time practice nurses. The clinical team are supported by a full time practice manager, two health care assistants and reception and administration staff.

The practice is open between 8.00am-6.30pm daily except one Wednesday in the month when the surgery closes for training purposes at 1pm. Routine appointments are available from 8.30am-11.00am on a Tuesday, and from 9.00am-11.00am on other weekdays. Additional appointments are released after 11am to see urgent patients who need to be seen on the day. Afternoon appointments are available from 2.00pm-6pm on every afternoon apart from Wednesday, when the practice is open for emergency and essential care only.

Every Wednesday afternoon from 1.00pm, and during the evenings and weekends, an out-of-hours service is provided for patients by Derbyshire Health United (DHU) via the 111 service.

The practice offers a range of enhanced services (services provided above those included within their core contract) including end of life care and minor surgery.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the

legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

- 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 our inspection, we reviewed a range of information that we hold about the practice and asked other organisations including Healthwatch, NHS England and North Derbyshire CCG to share what they knew. We carried out an announced inspection on 14 October 2015. During our inspection we spoke with staff including GPs, practice nurses, the practice manager and a number of reception and administrative staff. In addition, we spoke with health professionals outside of the practice regarding their experience of working with the practice team; this included a district nurse, midwife and care co-ordinator. We also spoke with patients who used the service, and representatives of the practice patient participation group. We observed how people were dealt with during their visit to the practice. We also reviewed 114 comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice encouraged staff to report and record significant events. Staff knew how to report any incidents including near misses, and a recording form was available on the practice's computer system. The practice ensured that any individual affected by significant events received an apology and were told about actions taken to improve care. The practice reviewed the significant events at a weekly staff meeting involving GPs, the lead nurse, practice manager and senior administration staff.

We found that staff used different methods to record incidents, rather than using the form available on the practice intranet. There was no annual review to consider any trends that may have occurred.

However, there was evidence of learning from significant events. For example, we saw the practice had instigated a review of patients using their own medidose (a compartmentalised container prepared with medications to be taken at specific times on a specified day). This followed an incident in which a patient had medication stopped by the out of hours' service, but then started to retake this medication on returning home as it was still stored within their own medidose which had been kept at home. A designated member of the administration team had been assigned responsibility to deal with patients using the medidose system.

We also saw that a positive incident had been recorded in which a patient was diagnosed with a serious condition despite presenting with what appeared to be low risk symptoms. This enabled the patient to receive the treatment required promptly and help keep them safe. It is good practice to review positive cases as part of the incident reporting process to share good practice with the rest of the team.

Safety alerts were cascaded to appropriate staff members. When a medication alert had been received, the GP prescribing lead would conduct a search of patients to determine if any follow up action was indicated. We viewed evidence that this had taken place on a number of occasions over the last two years, although this had not been written up as a reference document for other staff.

Overview of safety systems and processes

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

- Safeguarding arrangements were in place to protect children and adults from abuse that reflected relevant legislation and local requirements. We spoke to staff who demonstrated they understood their responsibilities for safeguarding and all had received training relevant to their role. There was a practice safeguarding policy in place which outlined how to report concerns if any staff member observed or became aware of a potential or actual safeguarding issue. There was a lead GP with responsibility for safeguarding, but no specific practice meetings had taken place to discuss and review safeguarding cases. The health visiting team told us that GPs liaised regularly with them regarding any safeguarding concerns.
- Safe systems were observed to review incoming correspondence from the out of hours' service and pathology laboratory results. These were reviewed and checked by the GP as indicated. Any necessary actions were undertaken and recorded.
- Patients could request for a chaperone to be present for any intimate examinations. This information appeared on the log-in screen when patients booked in for their appointment. There was also a notice displayed on the reception desk. The practice chaperone policy required updating in accordance with current guidance.
- Some employees, including clinical staff, who acted as chaperones had received a disclosure and barring check (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. However, when this was raised with the practice manager, immediate action was taken to initiate the DBS checks for those staff that required one.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a designated building manager who covered all services housed within the medical centre, and there was good liaison between this individual and the practice. A health and safety policy was available. The practice had up to date fire risk assessments and fire drills had been carried out. 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 also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella.

- The practice was cleaned to a high specification and we observed all areas to be clean, tidy and well maintained. There were cleaning schedules for each room and there was a system to monitor the standards of cleaning. A practice nurse was the infection control clinical lead although infection control audits were undertaken by the practice manager. Actions identified by the audit had been completed. Staff had received infection control training in November 2014 and a policy was in place.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, recording, handling and storage). There was a designated GP prescribing lead who liaised with the CCG's pharmacy team. Regular medication audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. We noted that some prescriptions were left in printer trays creating a potential security issue as the rooms were not always locked.
- Recruitment checks were carried out and the four files we reviewed showed that information relating to recruitment checks was incomplete. Whilst some information was available, there were gaps including, references, qualifications, registration checks with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- 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 that enough staff were on duty

Arrangements to deal with emergencies and major incidents

There was a system to notify the rest of the team if a medical emergency occurred. A message would appear on computer screens advising which room required assistance, and there was access to a panic alarm in each consulting room. All staff received annual basic life support training and there were emergency medicines available in an accessible location. All the medicines we checked were in date and fit for use. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. An incident had occurred the week before our inspection when a patient had a suspected heart attack. The patient was cared for appropriately and transferred safely to hospital.

The practice had a comprehensive business continuity plan in place for major incidents such as loss of services including electricity or building damage. This plan had been updated in 2015 and included emergency contact details for staff.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice utilised a computer based programme called Map of Medicine to access information on National Institute for Health and Care Excellence (NICE) best practice guidelines, and to consult disease management pathways. Clinical staff undertook assessments and treatment in line with current evidence based guidance and standards and the practice had systems in place to ensure all clinical staff were kept up to date. The practice monitored that these guidelines were followed via discussions amongst the clinical team and audits.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The most recent verified QOF results for 2013-14 were 99.5% of the total number of points available. 9.8% patients had been exception reported, which is slightly below the average within the CCG (the exception reporting rate is the number of patients which are excluded by the practice for specific circumstances such as repeated non-attendance when calculating their overall QOF achievement). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013-4 showed;

- Performance for diabetes related indicators at 99.7% was better in comparison to the CCG average of 96.8% and the national average of 90.1%.
- An achievement of 96.2% for hypertension related indicators was better the CCG average of 91.4% and the national average of 88.4%
- 88.6% patients diagnosed with dementia had their care reviewed in a face-to-face review in the last 12 months which was 1.8% higher than the CCG average and 4.8% above the national average.

The practice had undertaken a process to identify early or established heart failure, following the diagnosis of this condition in a relatively young patient who presented with symptoms more typical of asthma. The practice implemented a specific assessment for relevant patients and identified 4% of patients (just over 3% above the CCG and national averages) with this condition, who were then commenced on an appropriate treatment regime.

Clinical audits were undertaken by the GPs to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been several clinical audits completed in the last two years, two of these were completed audit cycles where the improvements made were implemented and monitored.

One completed audit had been undertaken on HbA1c levels (a measure of blood sugar) to see if this was equal to or below a target of 7.5% in diabetic patients. The audit had been repeated three times and the latest cycle demonstrated that the actions taken by the practice team had increased the number of diabetic patients achieving the targeted HbA1c from 51% to 64% in the last 2 years.

The practice worked with the CCG pharmacy team. When the practice was identified as a high prescriber of certain antibiotic drugs which had a correlation with the incidence of clostridium difficile (a type of bacterial infection that can affect the digestive system), they reviewed their approach to prescribing these drugs. By adopting a specific rationale as to when these drugs should be prescribed, the practice moved from being approximately 50% above the national average, to half of the national average.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- GPs had developed areas of expertise and acted as a resource for the team. For example, a GP led on prescribing issues and another acted as the main contact for diabetes. One GP had a special interest in dermatology and ran a pilot clinic once a week which other local GPs could refer into for assessment and minor surgery. This had led to a reduction in two week referral rates for suspected skin cancers. Another GP had an interest in Psychological Therapies including Cognitive Behavioural Therapy (CBT), and was a qualified CBT therapist.
- The practice manager had implemented an induction programme for newly appointed members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- There was an active appraisal system in operation at the practice, and all staff had received their appraisal in the preceding 12 months. The appraisal process was used as an opportunity to discuss the practice objectives with each staff member to match their development to the aspirations of the practice. Staff were supported to undertake training to meet personal learning needs and to cover and enhance the scope of their work.
- Staff training records evidenced training that included safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. Training records were recorded on the practice intranet but these did not contain full training records for clinical staff.

Coordinating patient care and information sharing

The practice held a fortnightly meeting chaired by the practice nurse to review the needs of their most complex patients, and additional meetings were arranged if required. We observed one of these meetings on the day of our inspection. We saw that this focussed on a patient centred approach to meet the range and complexity of people's needs and to assess and plan ongoing care and treatment to maximise outcomes for patients. The meeting included the GPs, a practice nurse, district nurses, an occupational therapist and a care co-ordinator. We were told that representatives from other services such as social services and community mental health services attended meetings when appropriate cases are discussed. We were informed how a patient had secured a temporary specialist placement at a head injury unit whilst refurbishments were done in the home to enable them to return and be cared for effectively. This was achieved by the team working together in the meeting to avoid an admission to a mental health unit.

A pharmacy was sited next to the practice. There was regular communication on medications between the pharmacy and practice and an internal telephone extension number had been installed to aid rapid communications. The pharmacist had recently attended a meeting with the practice administration team to review ways of working to increase efficiency.

The practice could demonstrate the effectiveness of its work by the low use of Accident and Emergency (A&E) and the out of hours' service. Figures for 2014-15, showed that out of hours' practice contacts were 141 per 1000 population, compared to the CCG figure of 214.

There was also a lower rate of emergency cancer hospital admissions in 2014 despite the practice having comparatively high numbers of cancer patients due to the significant number of patients aged 65 and over. This figure was 5.13 per 100 patients on the disease register, compared against the national average of 7.4.

Consent to care and treatment

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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

The practice identified patients who were in need of additional support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their weight, diet and smoking cessation. There was an in-house smoking cessation service managed by one of the health care assistants and this had achieved 30 successful quitters from 2013 to present. The practice still referred into the local smoking cessation service subject to each patient's requirements. New diabetic patients were referred to an education group for information and advice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 88.4%, which was above the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice encouraged patients to attend national screening programmes for bowel and breast cancer screening and had higher rates of screening uptake than both the CCG and national average.

The practice performed well in terms of childhood immunisation rates for the vaccinations given which were

Outstanding ☆

Are services effective?

(for example, treatment is effective)

mostly above CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 97.3% to 100% (compared to a national figure ranging from 95.2% to 98.9%) and for five year old children from 98% to 100%, which were generally 1-2% higher than the national averages.

The practice led a targeted annual flu campaign and used this as an opportunity to check for any other concerns, or undertake any outstanding reviews as part of the chronic disease register. Flu vaccination rates for the over 65s were 80.06%, compared to a national average of 73.24%, although the uptake for clinical risk groups (6 months to under 65 years) at 49.02% was below the national average of 52.29%

Health checks for new patients and NHS health checks for people aged 40–74 were available in the practice, and a large promotional poster and leaflets were available in the waiting room to advertise this service. 106 health checks had been completed in the previous 12 months and the practice aspired to increase further uptake. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection, we found patient care to be the primary focus of the practice team and this was integral to everything that was done by them. Many staff had worked at the practice for a number of years and they knew their patients extremely well. The ethos of the practice was to 'be part of a family, to be approachable, to be respectful and to be easy to talk to'.

We observed that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. A room was available next to the reception desk to discuss sensitive issues confidentially. The GP treatment room had a private corridor to the nurses' room, a utility room and toilets to create a suite that helped ensure privacy for patients.

The majority of the 114 patient CQC 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. We also spoke with three members of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their views were listened and responded to. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

The national GP patient survey results showed patients were happy with how they were treated and this was with compassion, dignity and respect. The practice was either above or in line with CCG averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 100% said they had confidence and trust in the last GP they saw or spoke with compared to the CCG average of 97% and the national average of 95%.
- 92% said the last GP they saw or spoke with was good at listening to them compared to the national average of 89%, and this was in line with the CCG average.
- 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

Care planning and involvement in decisions about care and treatment

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

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

- 93% said the last GP they saw or spoke with was good at explaining tests and treatments compared to a CCG average of 91% and a national average of 86%
- 93% said the last nurse they spoke to was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.
- 76% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care compared with a CCG average of 86% and a national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations including the 'Living Well With Dementia Programme' for people with dementia and their carer. There was also information for carers who were young people, or caring for someone with mental health needs.

Carers were identified for those patients on the practice disease registers. 80% of these patients had an identified carer. They were being supported, for example, by offering health checks, influenza vaccinations and referral for social services support. Information was available for carers to ensure they understood the types of support available to them.

Good

Are services caring?

Staff told us that if families had suffered a bereavement, the practice sent a card expressing their condolences. A representative of the practice would usually try and attend the funeral, both as a mark of respect and also to enable the staff member to have time to reflect on a patient with whom they had established a close relationship. Ongoing support was offered to bereaved relatives via a consultation or by directing them to find an appropriate support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups. For example;

- There were longer appointments available for people with complex needs such as those with a learning disability.
- There was an online appointment booking system, although only six online appointments were bookable per GP each week. Electronic prescribing was in place and the practice were working to promote this to encourage greater uptake.
- Home visits were available for older patients who were unable to get into the surgery
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, access to a hearing loop and translation services were available in the practice. One GP was trained in sign language.
- We were informed how a GP had told district nursing staff that they would respond to a patient's end of life needs regarding the use of a syringe driver (a battery-operated pump used to give pain relieving medication continuously under the skin for a period of time). The GP agreed to visit the patient outside of surgery hours if it was needed, although the patient was residing several miles away from the practice area.
- GPs facilitated access to the Crisis Intervention Service by prioritising urgent assessments on individual patients in need. This service can only accept referrals after the patient has been seen by a GP.
- Templates available on the practice computer system were not being fully utilised and access to a specific prescribing formulary was not used via the computer. This created a potential impact on efficiency and created some inconsistent approaches within the practice

Access to the service

The practice opened between 8am-6.30pm Monday to Friday, apart from Wednesday afternoon when the practice closed at 1pm for staff training. The practice received incoming telephone calls from 8.30am until 6pm, and paid their out of hours provider an additional half hour at the start and end of the day to cover any calls. A GP was available on call for any urgent appointments within each half hour period.

Pre-bookable appointments could be booked up to three months in advance and were available from 9-11am on a Monday, Wednesday and Thursday morning. On Tuesday, these appointments were available from 8.30am-10.30am and the practice planned to introduce appointments from 8.30am on a Thursday in the near future.

One GP undertook triage each morning from 9-10am and any patient requiring an urgent appointment would attend the surgery later that morning. Patients would be allocated an embargoed seven minute appointment slot, held specifically to accommodate urgent needs. There were seven of these appointments available each day although the practice informed us that all patients requiring an urgent assessment would be seen that day.

Afternoon appointments were available from 2.30pm-4.30pm on Tuesday and Thursday and this was extended until 5.30pm on a Monday and Friday. Emergency and essential care was provided on a Wednesday afternoon, although the surgery closed one Wednesday afternoon each month in order to participate in CCG organised learning events. There were no extended hours surgeries offered at the practice.

We reviewed the next available pre-bookable appointment on the day of our inspection and observed that patients had to wait approximately two weeks to see either a GP or a nurse, and this increased during periods of annual leave.

The practice had focussed on demand and access via the Productive Practice Programme in 2012. This resulted in changes being made to the service including the introduction of the triage process, which is valued as evidenced via patient feedback. However, the demand for appointments was creating long waits for patients and there was insufficient capacity in the system to see routine patients quickly enough. The practice informed us they did use locum GPs and that the salaried GPs worked extra hours as needed.

The practice were using remote monitoring to relieve pressure on appointments. For example, some patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

with hypertension could self-monitor their blood pressure and periodically send the readings through to be checked. Any abnormal results would be acted upon appropriately and the patient still attended for their annual review.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages. Some people we spoke to on the day, and some of the responses provided on comment cards, stated patients found it difficult to get appointments when they needed them. For example:

- 53% patients said they felt they normally have to wait too long to be seen compared to the CCG average of 63% and a national average of 58%.
- 67% patients described their experience of making an appointment as good compared to the CCG average of 76% and a national average of 73%.
- 75% of patients were satisfied with the practice's opening hours compared to the CCG average of 78%. This figure was the same as the national average of 75%.

Listening and learning from concerns and complaints

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

There was no information available to help patients understand the complaints system but there was a notice on the main reception desk informing patients they could make a complaint to the practice. This was included in a notice on the reception desk including details about chaperones and the availability of information sheets and could be easily overlooked. Patients we spoke with were not aware of the process to follow if they wished to make a complaint, although all those we spoke with stated they had never needed to make a complaint.

We looked at three complaints received in the last 12 months, including one anonymous comment which the practice used as a complaint from the NHS Choices website. The two complaints received directly by the practice had been reviewed and were satisfactorily handled in a transparent manner and dealt with in a timely way.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care where indicated. For example, following a complaint with regards to a stated delay in diagnosis, the team had reviewed a patient's consultation notes to see if patient's diagnosis should have been identified. Although this determined that the later known condition could not have been diagnosed from the patient's presentations in consultation, it allowed the practitioners to reflect on the circumstances of this case.

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 mission statement and had produced key objectives to deliver high quality care and promote good outcomes for patients. These objectives were built into each individual's appraisal discussion as a basis to align personal objectives into the overall practice aspirations.

Governance arrangements

The practice had a governance framework which supported the delivery of the objectives and good quality care, although there was sometimes a lack of documentation to provide full assurance of this.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. They were supported to access training to enable them to undertake their roles effectively.
- A range of practice specific policies were implemented and were available to all staff via the intranet.
- A programme of clinical audit was used to monitor quality and to make improvements, but this was not always formally recorded.
- Meetings were not always supported by minutes or agendas to provide an accurate record of discussions and agreed outcomes. There were no formally documented meetings relating to safeguarding concerns, although effective liaison was in place to protect children and vulnerable adults.

Leadership, openness and transparency

The GP lead in the practice had the experience and capability to run the practice and ensure high quality care. High quality and compassionate care were key to the practice's strategy. The lead GP was visible in the practice and staff told us that there was an open-door policy and staff were always listed to. There was a culture of openness and honesty.

The two salaried GPs worked part time and therefore the lead GP had to take clinical responsibility for most areas. The GP was actively trying to recruit a GP partner to assist with leadership in the practice. The practice manager provided effective management to the practice team and had led and implemented changes to the way the practice worked including the development of policies, and a review of ways of working to improve efficiency. The practice team were looking ahead in terms of succession planning to ensure they could build a team with the right skills to manage future demand.

The practice worked well with the other practices in the town, and engaged with them on a regular basis. The lead GP and practice manager also participated in CCG meetings and initiatives, and staff attended the monthly CCG organised training sessions on a regular basis.

The practice held a meeting at the start of the week which included the GPs, practice manager, senior nurse and senior administration staff to catch up on any important issues. Staff told us that regular meetings were held, although these were not always inclusive but rather focussed on particular staff groups. Staff said they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the practice. All staff were involved in discussions about how to run and develop the practice, and all members of staff were encouraged to identify opportunities to improve the service delivered by the practice.

We observed that minutes of meetings were often extremely brief where available and therefore it was difficult to determine the discussions that had taken place or the actions which had been instigated in response to any issues raised.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG with 14 members which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. This included a re-design of the process to answer incoming telephone calls which had resulted in a reduction in answering times from approximately one and a half minutes to 26 seconds on average. On the day of our inspection, the practice was

Are services well-led?

Good

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

running a flu clinic and this was actively supported by the PPG. The PPG were in attendance throughout the morning to talk to patients about their views and encourage new members to join the group.

Staff were able to make suggestions to improve service provision, and felt empowered to do so. One employee told us how greater flexibility was needed with appointments to accommodate those who may need to return the following week, and this was acted upon.

The practice had scope to increase the information available to patients on its website, for example how to make a complaint, and feedback from patient surveys and the PPG.

Innovation

The role of the champion for frail and older people offered responsive and effective care for patients. The practice did not have a community matron and this role had been designed to bridge this gap and ensure the effective management of patients with those most complex needs.

The building is ideally designed for future development and this is an area which the practice were mindful of in discussions with their CCG as part of the 21st Century workstream.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider had not operated effective recruitment procedures as they had not undertaken checks as detailed in Schedule 3, or undertaken risk assessments where this information was not available.** **The provider did not have robust procedures for undertaking criminal background checks. For example, no DBS check had been undertaken on the practice nurse or reception staff carrying out chaperoning duties.** 19 (2) (a) Schedule 3