Mixenden Stones Surgery

Quality Report

Mixenden Road
Mixenden
Halifax
West Yorkshire
HX2 8RQ
Tel: 01422249788
Website: www.caritashealth.org.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Mixenden Stones Surgeryon 22 April 2015. Overall the practice is rated as good.

Specifically, we found the practice was good in providing safe, responsive, caring, well-led and effective care for all of the population groups it serves.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. 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. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Calderdale Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and end of life care. It was responsive to the needs of older people and offered home visits and rapid access appointments for those with enhanced needs.

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. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided family planning clinics, childhood immunisations and maternity services. Staff ensured care for mothers, babies and young patients was safe, caring, responsive and effective. Immunisation rates were relatively high for all childhood immunisations. We saw good examples of joint working with midwives and health visitors. There was health education information relating to these areas in the practice to keep patients informed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified. 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 as well as a full range of health promotion and screening that reflected the needs of this population group.

Summary of findings

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. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people who had a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Eighty eight percent of people experiencing dementia had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. Staff had received training on how to care for people who had poor mental health or dementia.

Summary of findings

What people who use the service say

In the most recent information from Public Health England 2013/14 for the Caritas Group which includes the following surgeries at Woodside, Mixenden Stones and Shelf Health centre showed 64% of people would recommend this group of practices to others. This was lower than the National and local CCG averages. While 69% were happy with the opening hours, which was slightly lower than the local CCG average.

We spoke with three patients at Mixenden Stones Surgery on the day of our visit. All the patient comments were positive about the care provided by the GPs, the nurses and reception staff with many comments conveying the excellent service they received by the practice overall. They all felt the doctors and nurses were competent and knowledgeable about their health needs. One person told us they waited for an appointment but thought the triage system operated by the practice was amazing.

The practice has a Patient Participation Group (PPG) and we spoke with two members of the group. Patients said the practice was always clean and tidy.

Mixenden Stones Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP, a practice manager, a practice nurse, who were all specialist advisors, and a second CQC inspector.

Background to Mixenden Stones Surgery

Mixenden Stones Surgeryis located in Mixenden Halifax. The practice has good parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services. The practice provides primary care services for 9100 patients under a Personal Medical Services (PMS) contract with NHS England in the Calderdale Clinical Commissioning Group (CCG) area. The PMS contract is a contract between a general practices and NHS England for delivering primary care services to local communities.

Fifty six percent of the patients have a long-standing health condition while the English average was 54%.

The practice is one of three practices who form part of the Caritas Group Practice. The Caritas Group have three advanced nurse practitioners (female) and a diagnostic clinician (male) who are the partners for the group. There are also five male GPs, (one female GP, another advanced nurse practitioner, four practice nurses and two health care assistants. They are supported by four managers and 12 administration and reception staff who cover the three sites.

Mixenden Stones Surgery is open on Mondays, Wednesdays and Fridays 10am to 6pm, Tuesdays and Thursdays 8am to 4pm Extended hours are available, twice a week on a Tuesday and Thursday morning from 7:15 to 8;00. The extended hours are available to all patients who cannot attend during normal surgery hours and is by appointment only.

The practice treats patients of all ages and provides a range of medical services. Out of hours care is provided by the Local Care Direct service.

Why we carried out this inspection

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

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

Please note 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:

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 April 2015. During our visit we spoke with a range of staff including the management team, a GP, an advanced nurse practitioner (partner), a practice nurse, the education coordinator and two members of the reception staff. We also spoke with three patients on the day. We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed comments where patients had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for how they reported, recorded and monitored significant events, incidents and accidents. There were records of significant events which had occurred during the last 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda and a meeting was held monthly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, which included receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked one incident and saw records were completed in a comprehensive and timely manner. For example, we saw evidence of action taken as a result of a faulty plug on a fan heater. As a result of this it was agreed to immediately dispose of the fan heater, carry out a risk assessment and have all equipment PAT tested on an annual basis. Where patients had been affected by something which had gone wrong they were given an apology and informed of the actions taken, in line with practice policy.

National patient safety alerts were disseminated by the performance and contracts manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

They also told us alerts were discussed at monthly meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when they acted as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

clear policy which ensured medicines were kept at the required temperatures, this described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using patient specific directions which had been produced in line with legal requirements and national guidance. We saw evidence nurses and the health care assistants had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by either an advanced nurse practitioner or a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had established a service for patients to pick up their dispensed prescriptions at nearby locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure patients who collected medicines from these locations were given all the relevant information they required.

The practice employed a pharmacist who supported the practice with medicines management and undertook medication reviews. They would discuss with the clinicians any issues they had concerns about.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training about infection control specific to their role and also received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Staff we spoke with told us how they had received hand washing training. There was also a policy for needle stick injury and staff explained the procedure to follow in the event of an injury.

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

Sharps bins were appropriately located and labelled. The practice had access to spillage kits and staff told us how they would respond to blood and body fluid spillages in accordance with current guidance.

The practice was aware of legionella (a bacterium found in the environment which can contaminate water systems).We were told and evidence we saw confirmed the practice was carried out regular checks in line with this risk assessment to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers which indicated the last date they were tested. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. They were also in the process of researching a data logger which recorded these temperatures. We saw evidence from minutes of this.

Staffing and recruitment

Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate

professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy which set out the standards it followed when they recruited clinical and non-clinical staff.

Staff told us about the arrangements on how they planned and monitored the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. This was usually planned and available for staff six weeks in advance. There was also an arrangement in place for members of staff, which included nursing and administrative staff, to cover each other's annual leave. If GPs were on leave the practice used locum GPs to cover for their leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The performance and contracts manager and the patient services manager showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety risk assessment toolkit. Health and safety information was displayed for staff to see and we saw documented evidence of the risks assessed.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks were discussed at meetings. For example, a member of staff had shared the findings from a recent fire risk assessment to other members of staff. As a result they removed any faulty heaters with broken grills and implemented further PAT testing.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Emergency equipment was available, this included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly. The notes of the practice's significant event meetings showed staff had discussed a medical emergency which concerned a patient and the practice had learned from this appropriately.

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

A business continuity plan was in place to deal with a range of emergencies which could impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utility companies to contact if the electric, gas or water failed.

The practice had carried out a fire risk assessment which included actions required to maintain fire safety. Records showed staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The advanced nurse practitioners, GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the advanced nurse practitioners, GPs and nurses, staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The advanced nurse practitioners and GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The advanced nurse practitioners and GPs told us this supported all staff to continually review and discuss new best practice guidelines.

The advanced nurse practitioners and GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to the national average. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients who had recently been discharged from hospital. These patients had a named GP who looked at the discharge letters. Patients were reviewed by their GP or an advanced nurse practitioner according to need.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All advanced nurse practitioners and GPs we spoke with used national standards for referrals. We saw minutes from meetings where regular reviews of elective and urgent referrals to secondary care and other primary care services were made, and improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with advanced nurse practitioners and GPs showed the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management. The information staff collected was then collated by the practice manager and deputy practice managers to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last two years. Some of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We saw evidence of a spirometry screening audit 2014/2015 as well as the subclinical hypothyroidism (mild thyroid failure)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review. The practice met all the minimum standards for QOF and was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a

Good

Are services effective?

(for example, treatment is effective)

group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked patients who received repeat prescriptions had been reviewed by the advanced nurse practitioners or GPs. They also checked all routine health checks were completed for long term conditions such as diabetes and COPD and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when medicines were prescribed. The evidence we saw confirmed the advanced nurse practitioners and GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support and fire training. We noted a good skill mix among the advanced nurse practitioners and GPs. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals these identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example internal and external training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended times for their consultations and had access to the advanced nurse practitioners or GP partner throughout the day for support. One of the advanced nurse practitioners was an associate GP trainer.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, the administration of vaccines, taking blood samples and providing healthy lifestyle advice and support healthcare services, such as smoking cessation. Some staff had extended roles on the management of chronic diseases such as diabetes, asthma and heart disease. They also had skills in all aspects of family health, public health, health promotion, travel health and sexual health were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital which included discharge summaries and the 111 service both electronically and by post. The practice outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The clinicians who saw these documents and results were responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held fortnightly multidisciplinary team meetings to discuss the needs of complex patients. For example, those who had end of life care needs those who were at risk of an unplanned admission. The patient status markers made the triaging of calls for example with carers and housebound patients easier. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. (Choose and Book is a

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Are services effective?

(for example, treatment is effective)

national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence meetings had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. The care plans were reviewed annually or more frequently if circumstances changed and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competencies. (These are used to help assess whether a child under the age of 16 years has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice supported patients to manage their health and well-being and offered NHS health checks to all its patients over 40. They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance.

The practice identified patients who needed ongoing support with their health. They kept up to date registers for patients who had a long term condition, such as diabetes or asthma, which were used to arrange annual health reviews. Registers and annual health checks were also available for vulnerable patients, such as those with a learning disability, and the over 75s. They also identified other 'at risk' groups for example those patients who received end of life care. These groups were offered further support in line with their needs.

Healthy lifestyle information was available to patients via leaflets and posters in the waiting room and also accessible through the practice website. This included smoking cessation, weight management and travel health. Patients were signposted to other services as the need arose.

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Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey where from a sample of 389 questionnaires, 115 (30%) responses was received.

A survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires had also been sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed 88% of respondents described their overall experience of their surgery as fairly good or very good. This was above the national average of 86%. The practice satisfaction scores on consultations with doctors and nurses were 78% of practice respondents who said the GP was good at listening to them and 77% said the GP gave them enough time during a consultation, which was below the national average respectively.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 15 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection and two members of the patient participation group. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw consultation / treatment room doors were closed during consultations and conversations which took place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when they discussed patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A system had been introduced to allow only one patient at a time at the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the patient services manager. The patient services manager told us they would investigate these and any learning identified would be shared with staff. There was also evidence of learning which took place at staff meetings and minutes showed what had been discussed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 80% of practice respondents said the GP involved them in care decisions which were just below the national average and 83% felt the care they received from the practice was satisfactory, good or excellent.

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

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Members of the (PPG), the patients we spoke with on the day of our inspection

Good

Are services caring?

and the comment cards we received were also consistent with this information. They said they had received help to access support services to help them manage their treatment and care when it had been needed. These highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us if families had experienced bereavement, their usual advanced nurse practitioner or GP sent out condolence cards. This was followed up with giving them advice on how to access further support if needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them. We saw evidence where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. We were told the practice engaged in the Practice Engagement Scheme and attended monthly meetings.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).This included local telephone numbers being used at the surgery instead of the 0844 number.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, for example asylum seekers, those with a learning disability, travellers and carers.

The practice provided equality and diversity training. Staff we spoke with confirmed they had completed the training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services met the needs of patient with disabilities with wide entrance doors and ramps. The practice was situated on the ground floor of the building.

We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a majority population of English speaking patients though it could cater for other different languages through translation services which they stated they used as required.

Access to the service

Appointments were available on Mondays, Wednesdays and Fridays 10am to 6pm, Tuesdays and Thursdays 8am to 4pm. There is a triage system which we were informed dealt with around 160 calls per day. The advanced nurse practitioner and GP stated all those who needed to be seen on the day were seen. With having three sites patients were also offered appointments at the other practices.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes either by the nurse or GP to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed they could see a nurse or doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day they contacted the practice.

The practice's extended opening hours on Tuesday and Thursday mornings from 7:15 to 8:00 was particularly useful to patients with work commitments and were by appointment only. Plus the practice had appointments for those who attended school and did not wish to break school time.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system in the practice leaflet

Good

Are services responsive to people's needs?

(for example, to feedback?)

and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at nine complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way and displayed openness and transparency with dealing with the complaint.

The practice reviewed complaints to detect themes or trend and lessons learned from individual complaints had been acted on.

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. We found details of the vision and practice values were part of the practice's strategy and practice development plan. These values were clearly displayed on the website and in the staff room. The practice vision and values included to provide exemplary healthcare and education solutions for the enrichment of all their communities.

All the members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of these policies and procedures and staff confirmed they had read the policy and when. All the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. We spoke with three members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it performed in line with national standards. We saw QOF data was discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice had achieved 93% of achievable QOF points.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the spirometry screening audit, which was not routinely undertaken in general practice, to provide early detection of COPD particularly in smokers and to prevent progression of the disease.

The practice had arrangements for how they identified, recorded and managed risks. The performance and contracts and patient services manager showed us the risk log, which addressed a wide range of potential issues, for example the fire risk and trip hazards. We saw the risk log was regularly discussed and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, with the risk of electrocution the practice disposed of a heater immediately and checked the others.

The practice held monthly governance meetings. We looked at minutes from these meetings and found performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes team meetings were held regularly, at least monthly and staff told us there they had the opportunity and were happy to raise issues at these meetings. A 'no blame' culture was evident at the practice.

The business manager was responsible for human resource policies and procedures. Staff told us there was an open culture within the practice and all members of the management team were approachable, supportive and appreciative of their work.

We reviewed a number of policies, for example recruitment policy and infection control policy which was in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through, comment cards and complaints received). We looked at the results of the annual patient survey which identified the majority of the patients did not utilise the practice website. We saw as a result of this the practice ensured the website was kept up to date and links were provided on the practice booklet. Another example was to advertise online services more extensively. In order to achieve this the practice made sure posters were displayed in the waiting rooms.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups which included older people and the working age population. The PPG had carried out surveys

Are services well-led?

Good

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

and met every quarter. The performance and contracts manager and patient services manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through generally through staff meetings, appraisals and discussions. 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 in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had staff protected learning days where trainers attended.

The practice was a GP training practice and provided a range of clinicians who undertook teaching and assessment of other healthcare professionals. These included qualified nurses, doctors and nursing/medical students who were undertaking professional education and training courses. At all times the trainees would be supervised by a senior clinician.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and training days to ensure the practice improved outcomes for patients. For example, a patient had experienced a delay in receiving an abnormal chest x-ray result from the hospital. As a result the patient was fast tracked.