Malthouse Surgery

Quality Report

The Charter
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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 Malthouse Surgery on 10 February 2015. Overall the practice is rated as good. We found the practice to be good for providing safe, effective, caring and responsive services and for being well led. It was also good for providing services for the all of the six population groups we assessed.

During this inspection we followed up on concerns regarding safeguarding children and vulnerable adults and staffing checks identified during our previous inspection in July 2014. Following that inspection an action plan was sent to us by the practice, detailing how they would meet compliance. We found the practice had addressed the concerns we identified.

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.
- Communication channels and regular meetings were available to all staff which enabled them to be involved the running of the practice.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff training was monitored and training required by staff to fulfil their roles was delivered. However, Mental Capacity Act 2005 awareness among nursing staff and guidance to assist staff could be improved.
- Patient feedback showed 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.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- A blood sample centrifuge (required in preparing blood samples for testing) was available onsite meaning patients had greater flexibility in when they could have their blood tests undertaken.

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

The provider should :

- Provide nurses with awareness and guidance on the principles of the Mental Capacity Act 2005 to support them in considering the act in their roles.
- Test the spirometer in line with its manufacturer's instructions to ensure it functions properly when used.

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. There were systems to ensure medicines were stored correctly and within their date of expiry. However, the monitoring of vaccine fridges indicated that action was not always taken when staff found the fridges were at the wrong temperature. Directives required for health care assistants to administer vaccines were not in place.

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 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. However, the awareness among nursing staff of the Mental Capacity Act 2005 could be improved. Staff worked with multidisciplinary teams in planning and delivering care, such as liaison with district nurses and palliative care teams. The practice had employed a specialist diabetic nurse in response to below average outcomes in diabetic care in recent years. GPs told us this had improved the outcomes for diabetic patients in recent months.

Are services caring?

Good

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

Summary of findings

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Some patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. However, patient feedback also showed that phone access was a problem and the number of patients who reported being able to see a GP within a day was well below national average. 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 that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

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. The practice had considered and was in process of planning for its future in light of the need to move premises. 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 a virtual reference group and was engaged with regularly. 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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. End of life care was well managed and included external professionals in its planning and implementation. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The premises were easily accessible for patients with limited mobility.

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 that 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. A blood sample centrifuge was available onsite meaning patients had greater flexibility in when they could have their blood tests undertaken. Where any improvements to the management of long term conditions were identified, they were acted on.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, and systems to ensure staff were aware when seeing children who were at risk of harm or abuse. Immunisation rates were above average for most standard childhood immunisations. Appointments were available outside of school hours, including alternate Saturdays. The premises were easily accessible for patients attending with prams and buggies. Sexual health services were available on site.

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

Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended hours appointments were available two days after normal working hours and every other Saturday. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. A blood sample centrifuge was available onsite meaning patients had greater flexibility in when they could have their blood tests undertaken.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Staff received appropriate levels of training in safeguarding adults and children.

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. Patients experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary 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 about how to access various support groups and voluntary organisations

Summary of findings

What people who use the service say

The feedback from the 45 patients who left comment cards for the inspection team were generally very positive about the quality of the service. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of approximately 200 patients undertaken by the practice and patient participation group (PPG) and patient satisfaction questionnaires 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 that this was with compassion, dignity and respect. For example, data from the national patient survey showed 94% of practice respondents saying the GP was good at listening to them and 93% saying the GP gave them enough time.

Patients said they felt the practice offered a caring and helpful service on the comment cards we received. Some comments were less positive but these related to the appointments. Some comments noted that the experience at reception was not always positive. The practice survey noted an improvement from the 2013 to the 2014 survey in the response to patient experience at reception with 94% of patients stating that receptionists were helpful. Patients noted being treated with respect and dignity on the comment cards. Ninety six per cent of patients said their GP treated them with care and concern on the practice survey.

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 92% of practice respondents said the GP involved them in care decisions and 94% of patients felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 96% of patients said GPs explained things clearly to them. The feedback was also very positive regarding nurses. Patient feedback on the comment cards we received was also positive and aligned with these views.

The GP national survey found that patients were not as satisfied with the appointment system when compared to other practices in the CCG. The practice had taken steps to improve the telephone system to make it easier for patients to book appointments. However there was positive feedback regarding the ability to see a named GP and the results were above the CCG average. Comment cards left by patients provided mixed feedback regarding the appointment system with some patients stating they thought it worked well and others saying it was difficult to book an appointment. Ninety four per cent of patient said the last appointment they got was convenient on the 2014 GP survey.

Areas for improvement

Action the service SHOULD take to improve

- Provide nurses with awareness and guidance on the principles of the Mental Capacity Act 2005 would support them to ensure they always considered the act in their roles.
- Test the spirometer in line with its manufacturer's instructions to it functions properly when used.

Outstanding practice

- A blood sample centrifuge (required as part of preparing blood samples for testing) was available onsite meaning patients had greater flexibility in when they could have their blood tests undertaken.

Malthouse 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 and a CQC national nursing adviser.

Background to Malthouse Surgery

Malthouse surgery is located in the centre of Abingdon. The practice rent the premises from the local council and share the building with staff from a local NHS Trust. Patients are registered from the main town of Abingdon and from local villages and rural communities.

Over 19,000 patients are registered with the practice. Twenty per cent of the registered patients are over the age of 65. This is above the Oxfordshire average. The practice performs well against nationally recognised quality standards. The Quality and Outcomes Framework data available to CQC shows over 94% of targets are met. A wide range of primary medical services are provided including clinics for patients with long term conditions and for child health.

Care and treatment is delivered by 12 GPs, a nurse practitioner, four practice nurses, two healthcare assistants and two phlebotomists (phlebotomists are staff trained to take blood tests). The GPs and nurses are supported by a practice manager, patient services manager and a team of administration and reception staff.

The practice is a member of Oxfordshire Clinical Commissioning Group (CCG) and the South West Oxford Locality sub group of the CCG. One of the GPs and the practice manager attend CCG meetings.

The Malthouse Surgery,

The Charter

Abingdon

Oxfordshire

OX14 3JY

and

Appleton Surgery,

Appleton Village Hall

Oakesmere

Abingdon

OX13 5JS

We visited the Malthouse surgery but did not visit The Appleton Surgery as part of this inspection.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

Detailed findings

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

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Oxfordshire Healthwatch, NHS England and Public Health England. We visited Malthouse Surgery on 10 February 2015. During the inspection we spoke with GPs, nurses, the practice manager and reception staff. We obtained patient feedback from comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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)

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 were communicated and investigated. 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 in team meetings. 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 reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred in the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda and dedicated meetings had been held twice in the last six months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, issues with coding patients on their personal records to identify any safety issues was a concern and had been identified as a significant event. This was discussed with staff including the action identified to ensure improvements to record coding took place. The practice audited these changes to ensure the coding practices were improved. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Complaints which identified something that affected patients and the practice identified something had gone wrong, they investigated the concern, informed staff of any learning, reviewed protocol and policies and issued an apology where this was appropriate.

National patient safety alerts were disseminated by the practice IT lead to staff. They also told us alerts were discussed at 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 that all staff had received relevant role specific training on safeguarding. GPs had undertaken level three child 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 appointed dedicated GPs as leads 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, for example children subject to child protection plans. We saw examples of how the system flagged patients who may be at risk of abuse.

There was a chaperone policy which was visible in consulting rooms but not in the waiting room. All staff who undertook chaperone duties had been trained to be a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Although regular checks

were undertaken, we saw from records that there were occasions when the temperature of the vaccine fridge exceeded the maximum. However, staff had not reported or acted on this when it was recorded. The high temperatures recorded did not indicate that the vaccines were rendered ineffective. However, action should have been taken to ensure that the high temperatures were not repeated.

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 administered vaccines using directions that had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which they prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. A nurse administered a specific treatment for some patients who suffered from depression. The system for checking on patients who may have missed their treatment was not formalised and the responsibility was solely with the nurse to periodically check these patients.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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 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 received induction training about infection control specific to their role and received regular updates. We saw infection control audits were undertaken and nearly all improvements identified for action were completed. The audit from May 2014 noted elbow taps were broken in one treatment room but they had not been fixed.

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. For example, 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Staff had their immunity to Hepatitis B checked and were provided with immunisations when required. Equipment was clean and staff knew who was responsible for ensuring equipment was clean and hygienic.

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. Disposable curtains were used in treatment rooms and we saw there was a system to change these annually. Purple lidded sharps boxes for specific needles and other sharps were not available.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy 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 that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. 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 were all calibrated annually. However, the spirometer was not checked as frequently as suggested in manufacturer's instructions to ensure it was producing accurate measurements.

Good

Are services safe?

Staffing and recruitment

Records we looked at contained evidence that 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). Since the last inspection applications for DBS checks on nursing staff had been submitted but due to a backlog within the locality, not all had been returned. The practice manager was able to show us the applications had been sent. The practice had a recruitment policy that set out the standards it followed when recruiting staff.

Staff told us about the arrangements for planning and monitoring 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 that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There was minimal use of locum GPs or stand-in staff due to the cover arrangements.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and provided relevant training to its staff.

Arrangements to deal with emergencies and major incidents

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

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence that new guidelines were disseminated and that the practice's performance was reviewed where necessary. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes and respiratory diseases. Practice nurses also led in specific areas of healthcare. This enabled the practice to effectively manage specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of specific medical conditions. We saw clinical meeting minutes which confirmed that this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was higher than other local practices. The practice was reviewing its use of anti-biotics in order to reduce the prescribing of these medicines. We completed a review of case notes for patients with high various long term conditions which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. GPs told us that all referrals, other than urgent referrals, had to be reviewed by other GPs before being sent.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that 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 monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had a system in place for completing clinical audit cycles. The practice showed us several clinical audits which had been undertaken in recent years. Audits were undertaken in response 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). For example, the practice had previously under-performed in the management of diabetes according to QOF data. The practice employed a diabetic nurse to assist in the management of these patients and was auditing its performance of managing diabetes to identify how improvements could be made. The GPs we spoke with were positive about the improvements to diabetic care as a result of this. The practice drew up a list of audits required for the following year each September. Staff choose which audits they will undertake. Outcomes from audits were shared with staff at clinical team meetings and the outcomes were accessible to staff on a shared drive.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed well on QOF across the majority of clinical outcomes for patients achieving 94% overall in 2014. Exception reporting was low, other than for hypertension, which was higher than the national average in 2014. Exceptions may be made when patients are not able to be seen or not able to receive treatment in line with national standards. The practice had responded to the exception reporting for hypertension by improving communication with patients to improve their attendance at check-ups and medication reviews.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks

Good

Are services effective?

(for example, treatment is effective)

were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. It 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 that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs. All the GPs attended local meetings to discuss clinical topics with other GPs and share learning. 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 that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There were systems in place to disseminate relevant learning through a structure of team meetings. For example, updates in clinical treatments and protocols were

shared with the nursing team on a monthly basis. We saw minutes of the various team meetings. All staff groups took part in the quarterly review of significant events. We saw that the minutes of the meeting, including the learning points were circulated to all staff.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines.

Working with colleagues and other services

The practice worked with the district nursing team, health visitors and midwifes. GPs told us there was a clinical meeting every month and the community team was invited. This included the district nurses and palliative care nurses. The minutes of the meetings showed us that care of patients that required the input from various staff was discussed to ensure co-ordinated care was given. For example, the support required by patients in receipt of palliative care was discussed and co-ordinated. There was evidence of working with other healthcare professionals and voluntary bodies. Clinics were held at the practice by counsellors. Patients and carers were informed about local community groups including support groups for the elderly and the carers' forum.

Technology was used to support working with the local hospital. For example e-mails and photographs could be exchanged with dermatologists at the hospital to obtain advice about and diagnosis of skin conditions. Patients could receive a diagnosis and treatment without the need to attend hospital clinics. The practice operated a system of reviewing discharge letters within three days of their receipt. The lead GP told us this improved the support they gave patients who had an in-patient stay. For example, if a hospital doctor asked the GP to change a prescription this was able to be followed up within three days.

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 used the Choose and Book system (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to 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. The practice was in the process of implementing a new system.

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the staff we spoke with understood the key parts of the legislation. Nurses

Good

Are services effective?

(for example, treatment is effective)

gave examples of when they had refused to provide specific treatment if they believed an individual was unable to consent due to a mental health concern or believed a patient lacked capacity. However, nurses were not fully aware of when and how the act should be applied in the provision of care. There was no policy to help staff in assessing patients who may lack capacity to make decisions, in order to appropriately make and record a best interest decision for example. The practice had undertaken a do not attempt resuscitation audit. Staff were aware of their responsibilities in gaining consent for specific procedures such as for all minor surgical procedures.

Health promotion and prevention

GPs told us of a range of health promotion services they were able to access for their patients. For example, smoking cessation counselling was available in the practice. The GPs were able to refer patients to a dietician for weight management advice. Patients with alcohol misuse problems were referred to local support services. Patients seeking support for drug misuse problems were referred to the local team and shared care agreements were entered into when appropriate. Health information was made available during consultation and GPs used literature available from online services to support the advice they gave patients. A range of health promotion information was available in both the main waiting area and in clinical rooms. The practice website also contained health promotion advice and links to other relevant websites. For example 'Lifecheck' (Lifecheck is a free NHS service advising patients and their families on how to improve their health.) The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice kept a register of all patients with a learning disability and we saw where patients had been offered an annual health check. The practice had also identified the smoking status of 90% of patients over the age of 16 (above the national average) and actively offered nurse-led smoking cessation clinics to 91% of these patients.

The practice's performance for cervical smear uptake was 77%, which was slightly below the CCG average. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was above average for the CCG, with most immunisation rates over 95%. Flu vaccinations were offered and the uptake among those over 65 and those considered at risk due to medical conditions was above national average, with uptake at 75%and 52% respectively. Mental health services were used by the practice to encourage those suffering with mental health to receive addition support. Sexual health services were available on site.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of approximately 200 patients undertaken by the practice and patient participation group (PPG) and patient satisfaction questionnaires 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 that this was with compassion, dignity and respect. For example, data from the national patient survey showed 94% of practice respondents saying the GP was good at listening to them and 93% saying the GP gave them enough time. The responses regarding specific GPs that we looked at was 95% positive.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a caring and helpful service. Some comments were less positive but these related to the appointments system. Some comments noted that the experience at reception was not always positive. The practice survey noted an improvement from the 2013 to the 2014 survey in the response to patient experience at reception with 94% of patients stating that receptionists were helpful. Patients noted being treated with respect and dignity on the comment cards. Ninety six per cent of patients said their GP treated them with care and concern on the practice survey.

Staff and patients told us that 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 that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This reduced the likelihood of patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. There was a private room available if patients did not want to speak with staff in the public areas of the practice.

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 92% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 96% of patients said GPs explained things clearly to them. The feedback was also very positive regarding nurses. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that phone translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room informed 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. The practice worked with the local council in providing grants to carers where they required additional support. Support services for patients with mental health conditions were promoted by the practice. A befriending service was supported by the practice.

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 patient's 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. GPs from the practice visited patients in local care and nursing homes and links had been built with these homes. Patients living in these homes had a named GP to support continuity of care.

A blood sample centrifuge was available onsite meaning patients had greater flexibility in when they could have their blood tests undertaken. The practice had a dementia register to enable it to manage the care of patients with the condition and in order to manage their care with other services. A service for supporting patients with cancer on a wide range of concerns was promoted by the practice. Equipment which made it easier for patients who had limited mobility was available in consultation rooms such as benches and chairs.

GPs told us the practice engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) regularly to discuss local needs and service improvements that needed to be prioritised. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from their patient survey. For example, changes to the phone lines had been made in order to improve access to reception.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Information for deaf patients was provided in leaflets. The practice had access to online and telephone translation services.

The premises and services had been adapted to meet the needs of patient with disabilities or limited mobility. There was a ramp suitable for wheelchairs and mobility scooters at the main entrance to the practice. The premises had wide corridors and there were ample consultation and treatment rooms to see patients on the ground floor.

We saw that 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.

Access to the service

Appointments were available from 8am to 6.30pm pm on weekdays. There were extended hours two evenings a week where the surgery was open for pre-booked appointments until 8pm and also on alternative Saturday mornings pre-booked appointments are available. The extended hours were particularly useful to patients who worked full time.

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 patients who required them, by a named GP and to those patients who needed one.

The GP national survey found that patients were not as satisfied with the appointment system when compared to other practices in the CCG. The practice had taken steps to improve the telephone system to make it easier for patients to book appointments. However, there was positive feedback regarding the ability to see a named GP and the results were above the CCG average. Comment cards left by patients provided mixed feedback regarding the appointment system with some patients stating they thought it worked well and others saying it was difficult to book an appointment. Ninety four per cent of patient said the last appointment they got was convenient on the 2014 GP survey.

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. We looked at several complaints and found they were investigated robustly and responded to.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice reviewed complaints regularly to detect themes or trends at staff meetings. We saw that information was available to help patients understand the complaints in the form of leaflets and information on the website.

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 saw the practice had a strategic plan covering the years 2013 to 2015. The strategic plan included the vision of the practice and a mission statement and it had been shared with staff. The practice had a succession plan. There was uncertainty over the future of the premises as the local council was planning to redevelop the site where the practice was based. The practice leadership were fully engaged in the discussions about the future of the site to ensure they would be able to continue providing services to their patients.

All the staff we spoke with were committed to the values of patient centred care and knew what their responsibilities were in relation to delivering the values.

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 policies and found they had been reviewed regularly 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 partner was the lead for safeguarding. Staff 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 was performing in line with national standards. We saw that QOF data was discussed at staff meetings and action plans were produced to maintain or improve outcomes. For example, where performance in diabetic care had been significantly below national average in one QOF outcome, the practice had taken action to improve diabetic care. This included employing a diabetic nurse.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw a comprehensive programme of clinical audit was undertaken. This was planned and delivered based on the needs of the practice and patient outcomes rather than individual GP interests. GPs had the opportunity to pick the audits to undertake which they most wanted to or which suited any specific expertise. Audit outcomes were shared with staff to ensure learning outcomes were disseminated. Where necessary they led to changes in practice.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. These included risk assessments on the premises and common risks, such as fire safety.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that partner away days were held but they did not include all the practice staff. Staff we spoke with knew who to report concerns to about specific issues such as safeguarding and also had line managers to ensure they knew where they could access support if needed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, feedback specific to each GP and was undertaking the friends and family test. We looked at the results of the annual patient survey and saw there was some negative feedback about the telephone system and accessing appointments. The practice had responded to this feedback by changing the telephone system to increase the amount of calls that could be taken. Most feedback from surveys and specific GP surveys that we looked at was very positive. The practice manager showed us the analysis of the last patient survey. The results and actions agreed from these surveys were available on the practice website. The practice had an active virtual patient participation group (PPG) which communicated via e-mail and had in excess of 70 patients involved. The group was engaged with regarding proposed changes to the services provided. The practice manager told us the group was diverse and an effective means of engagement with a representative group of the local population.

Are services well-led?

Good

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

The practice had gathered feedback from staff through meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, a case of a superbug contracted by a patient registered at the practice was identified as a significant event and discussed at clinical team meetings to disseminate any learning from the event.

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.

This section is primarily information for the provider

Enforcement actions

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.