Dr Azmeena Nathu

Quality Report

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Date of inspection visit: 19 February 2015
Date of publication: 16/07/2015

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?	**Outstanding** ☆
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Azmeena Nathu, Pennygate Health Centre on 19 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, caring and responsive services. It was outstanding for providing effective services. It was good for providing services for older people; patients with long term conditions; families, children and young people; working age people and those recently retired; people experiencing poor mental health and people whose circumstances may make them vulnerable.

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.
- Using the Quality and Outcomes Framework as a measure, the practice performance was consistently high and exceeded the CCG and national averages in all areas.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and 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.
- Patients said they found it easy to make an appointment 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.

Summary of findings

We saw one area of outstanding practice;

- The practice worked in partnership with a charitable trust that had been established by the GP with the aim of meeting the needs of vulnerable members of the local community.

However there was an area of practice where the provider needs to make improvements.

Importantly the provider should;

- Ensure that clinical audits include a second cycle to complete the process.

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.

Medicines were managed safely and effectively.

We found the premises to be clean, with effective infection control and prevention measures in place.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Data showed patient outcomes were at or above average for both the locality and nationally. 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. All staff, with the exception of one new member, had received an annual appraisal.

Staff worked well with multidisciplinary teams.

The practice worked closely with other services to meet the needs of vulnerable and disadvantaged people in the community. In particular the relationship between the practice and the Pennygate Foundation, a charitable trust, was proving invaluable in meeting the needs of the disadvantaged and helping to improve their health and well-being.

Are services caring?

Good

The practice is rated as outstanding for providing caring services. The practice had worked pro-actively in meeting the needs of vulnerable and disadvantaged patients and had established a charitable trust, the Pennygate Foundation, a health and well-being centre for the local community. The patient participation group was dynamic and effective in raising money for the benefit of disadvantaged patients.

Summary of findings

Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture with a strong emphasis in reaching out to groups of patients such as migrant workers and their families.

Patients and carers were unanimous in their praise for the dedication and caring attitude of the GP and the staff in general.

Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our 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.

Urgent appointments were 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 that the practice responded quickly to issues raised.

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 and dynamic and worked closely with the practice GP and nurse. Staff had received inductions and attended staff meetings.

The GP worked alone in delivering care to the patient population but we found her to be dedicated and comfortable with the time demands this placed upon her.

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 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.

Shingles vaccines were offered to those who were eligible and a take up of 75 % had been achieved.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The nurse had a lead role 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 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 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. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. The practice encouraged parents within the migrant population to bring their children for immunisations in line with NHS schedules as it had been recognised that immunisation schedules differed across European countries.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice website signposted patients to other healthcare services as well as a full range of health promotion and screening that reflects the needs for this age group. For example the practice had exceeded the target figure of 80% of women eligible for a cervical smear test.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. 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.

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). All of the patients experiencing poor mental health, 89.2% had received an annual physical health check in the year to date. 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. All of the patients diagnosed with dementia had been reviewed in the year to date. The Pennygate Foundation had a dementia support group.

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

Summary of findings

What people who use the service say

During the inspection we spoke with patients and carers that used the practice and met with chair of the Pennygate Patient Link (PPL) The PPL is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We spoke with ten patients during our visit. We reviewed 18 comments cards that had been provided by CQC on which patients could record their views. We also received six letters where patients had recorded their experiences. All the patients we spoke with, and all of the patients who had completed comments cards and letters, emphasised the caring attitude of the staff and dedication of the GP, giving her own time outside of surgery hours to help them with their and their dependents healthcare needs. They told us that the care and treatment they received was good and that they felt fully informed as to their treatment options. Their confidentiality and dignity was respected.

One patient described the GP as like 'Mother Teresa of Calcutta'. Another said she deserved a knighthood.

Patients said that the practice was clean and staff practiced good hygiene techniques.

We looked at the results of the National Patient Survey for 2014 and found that; 97% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG average 90%); 94% of respondents found the receptionists at the surgery helpful (CCG average: 90%) and 92% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG average 88%).

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Ensure that clinical audits include a second cycle to complete the process.

Outstanding practice

- The practice worked in partnership with a charitable trust that had been established by the GP with the aim of meeting the needs of vulnerable members of the local community.

Dr Azmeena Nathu

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included an additional CQC inspector, a GP, and a practice manager.

Background to Dr Azmeena Nathu

Dr Azmeena Nathu, Pennygate Health Centre, is located in Spalding, a south Lincolnshire market town with a population of approximately 29,000. The practice provides GP services under a Personal Medical Services (PMS) contract to 3,544 patients. The practice was established in 1987 by Dr Nathu. It is a dispensing practice, currently dispensing to 822 eligible patients.

The patient population has a relatively low deprivation score of 13.4 compared with a national average of 21.6, although within the practice population there was clear evidence of deprivation, particularly associated with migrant workers and their families. Both male and female life expectancy are slightly above the national average. The age distribution of people living in the CCG area reflects that of the national profile. The age profile of the practice showed that there was a higher percentage of younger patients and 8% aged 75 or over. 18% of the patient list were of non-British nationality, being predominantly Eastern European.

The practice has one female GP, one practice nurse, one health care assistant and three members of staff who have dual roles as dispensers / administrators. There are two receptionists and a cleaner who is employed directly by the practice.

The practice is located over two floors, though all areas accessed by patients were located on the ground floor.

The surgery is open from 8.45 am until 6.30 pm Monday to Friday, with GP consultations available from 9 am to 11am and 3.30 pm until 5.30 pm. On Wednesday the surgery closed at 3pm and GP appointments were available from 9am to 11am.

The practice lies within the NHS South Lincolnshire Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust.

The practice had not previously been inspected by the Care Quality Commission.

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 was 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.

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

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 February 2015. During our visit we spoke with a range of staff and spoke with ten patients who used the service. We talked with patients and their carers and family members. We reviewed 24 comment cards and letters where patients and members of the public shared their views and experiences of the service. We also received the views of a healthcare professional who works with the practice.

In advance of our inspection we talked with the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We also reviewed information we had received from Healthwatch, NHS Choices and other publically accessible information.

As well as visiting the surgery we also visited the premises of the Pennygate Foundation, which is a charitable trust set up to meet the needs of disadvantaged and vulnerable people in the locality.

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records and incident reports and minutes of meetings where these were discussed.

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 the four significant events that had occurred during the last year and we were able to review these. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including receptionists and administrators, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result.

National patient safety alerts were disseminated by the GP 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, an example being the outbreak of the Ebola virus in West Africa.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. 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.

The GP was the practice lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to 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.

Information on safeguarding vulnerable adults and children was displayed in the patent waiting area.

The practice had a chaperone policy in place. A formal chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure and is a witness to continuing consent to the procedure. Family members or friend may be present but they cannot act as a formal chaperone. Staff told us that chaperone duties were carried out by the healthcare assistant (HCA) or practice nurse. We spoke with the nurse who explained and understood their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination.

GPs used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. 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. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

Screen alerts on the practice's electronic records were utilised to make staff aware of any relevant issues when patients attended appointments; for example people with the same or very similar names and those that may have demonstrated aggression.

The practice actively monitored vulnerable patients, such as those with learning disability and the frail elderly and

was signed up to the enhanced service to help reduce the number of unplanned emergency admissions to secondary care. We were provided with examples of how the GP had worked with a learning disability consultant and undertook a joint domiciliary visit. There was also evidence of working with psychiatric and elderly medicine consultants and the use of domiciliary requests.

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. 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.

Antibiotic advice was in a written format to inform locum GPs and help reduce community acquired infections and bacterial resistance. The formulary was regularly updated and available to locums. We saw that the GP attended meetings with the CCG to discuss prescribing policy and guidance.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse had received appropriate training to administer vaccines.

The practice had a medicines management policy which included details of drugs held for use in a medical emergency. They had been recently reviewed.

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

The practice did not hold supplies of controlled drugs.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process worked in practice.

We saw the practice formulary and noted that it was regularly reviewed and a copy was made available for locum doctors to refer to.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

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. There was a yearly review of the cleaning specification to reflect any changes necessary. Patients we spoke with and comments cards we received said 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 through on-line learning resources. We saw evidence that infection prevention and control audits were carried out on a quarterly basis and that any improvements identified for action were completed on time.

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.

Hand washing sinks with liquid soap, hand gel and hand towel dispensers were available in treatment rooms. Hand hygiene training for all staff had been arranged to accommodate recently recruited staff. Curtains used to screen examination couches had been cleaned in accordance with the practice policy.

Good

Are services safe?

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 by an outside contractor.

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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical 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.

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. Records demonstrated that 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 more regular checks of the building, the environment, medicines management, dealing with emergencies and equipment. The practice also had a health and safety policy.

The practice has in place a process to respond to risk, by means of being flexible in their approach. For example during the course of our inspection, a mother with a baby came to the surgery as the baby was very unwell. The mother and baby were not patients of the practice but were visiting a patient. The GP made time to see the baby and mother immediately.

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. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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, access to the building and the incapacitation or death of the GP. The document also contained relevant contact details for staff to refer to.

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.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse 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 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 GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We reviewed data from the local CCG of the practice's performance for a range of indicators, including the number of emergency admissions, prevalence of coronary heart disease and prescribing of antibiotics and found them all to be comparable to or better than average.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions.

Discrimination was avoided when making care and treatment decisions. Interviews with staff 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 medicines management.

The GP 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). For example, we saw an audit regarding the prescribing of olanzapine, an atypical antipsychotic drug. Following the audit, the GP carried out medication reviews for patients who were prescribed these medicines to ensure the prescribing was appropriate. Another audit had been carried out into the prevalence of cardiology referrals.

The dispensary team had carried out an audit to establish the reason why patients were asking for urgent repeat prescriptions. The audit had identified that many patients forgotten about their need for a repeat prescription and had either run out of medication or were going on holiday. As a result a reminder slip was placed in every repeat prescription bag that detailed when their next prescription was due and to remind patients to re-order. A poster in the waiting area re-enforced the message.

We noted that none of the audits had been subject to a full cycle and subjected to a second audit to test the effectiveness or otherwise of the action identified in the original process.

We looked at the QOF data for the years 2012/13 and 2013/14 which were the last two years for which complete data was available. We saw that in both these years the practice had achieved very highly and had exceeded both CCG and national averages in every area. For example for 2013/14 the total QOF achievement was 1.3% above the CCG average and 5.4% above the national average. In specific areas such as chronic kidney disease and cancer diagnosis it had achieved 5.3% and 4.5% above the national average respectively. In the area of clinical results its figures exceeded the national average by 6.9%.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Using the QOF data for the current year 2014/15, we saw that the practice had been effective in recalling patients for review. For example, of the patients recorded as having chronic heart disease, patients living with dementia and those with asthma, all had been recalled and reviewed. In all other areas of chronic disease the practice had achieved high recall rates and was on target to review all by the end of the financial year. This practice was not an outlier for any QOF (or other national) clinical targets.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The team was making use of clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a 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 that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks 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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included dispensary, 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 that the GP had an interest in children's health, obstetrics and family planning. The GP had been re-validated (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).

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The practice nurse was expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties, for example the administration of vaccines and cervical cytology. She had an extended role and saw patients with long-term conditions such as asthma and diabetes. She was able to demonstrate that she had appropriate training to fulfil all 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 including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining 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 GP, or locum GP in her absence saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service to reduce emergency admissions to secondary care. The practice had identified the top 2% of most vulnerable patients falling into this category and had care plans in place. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The Pennygate Foundation

The GP and practice staff worked closely with a charitable trust called the Pennygate Foundation. This had been

established by the GP with aim of providing support, advocacy and advice for patients of the practice and others in Spalding. The GP had purchased a property next to the surgery which had been adapted to provide meeting, catering and office space to meet the needs of needy, vulnerable and disadvantaged people.

Practice staff told us how they referred patients to the Foundation in times of bereavement for example, and for other advice that was not strictly healthcare related but impacted upon the patients wellbeing.

The Foundation was managed by a retired GP and provided a range of services to the elderly, people with mental health issues, people with dementia and their carers, migrant workers and their families, the homeless and people with a learning disability. They also provided assistance to people experiencing substance and alcohol misuse. Advice and advocacy was available in arrange of issues including benefits advice, prison visiting, debt management, divorce, bereavement and social care.

We visited the centre and spoke to the manager, a volunteer and service users. We saw food being prepared and cooked that was provided by people coming to the centre but we were also made aware that food was also delivered to peoples' homes. Patients could also be provided with transport to the centre to mitigate the infrequent bus service and high cost of taxis. The manager explained how this service was of particular value to elderly, isolated and de-motivated people who were at risk of malnutrition and acute weight loss and the consequential effect on their health and well-being.

Chiropody services were available at much reduced rates by an independent foot care professional.

The centre offered short term care for people living with dementia, enabling their carers to have some time to themselves, for example to attend the hairdresser.

The Foundation had recognised the needs of people with mental health issues and the underlying triggers such as isolation and exclusion, bereavement, trauma, serious illness and palliative care. Patients who the GP believed may benefit from the services offered by the Foundation were personally introduced to the staff by her, as a means of re-assuring people who would be anxious in attending such a centre for help and assistance.

Migrant workers and their families were provided with information on registering with a GP practice and were given information about all the practices available to them. It had been recognised that many tended to purchase drugs via the internet and self-medicate at home. As well as providing support and advice in registering with a GP practice, the Foundation also provided free meals and food parcels to particularly needy families, some of who were supported by breadwinners on zero hours contracts with no guaranteed income, especially in times of inclement weather when crop harvesting ceased. Children from migrant worker families were provided with packed-up school lunches and the centre provided after school tea for children in need followed by support in reading and English language skills.

We saw evidence that a youth club was planned to help multicultural integration, an idea supported by the local Police.

The centre held exercise, weight management, meditation classes, relaxation techniques, sophrology (a therapy based on combination of techniques such as concentration, deep breathing, relaxation, visualisation and simple movements), gardening, dance and movement sessions. Patients were referred to the centre by the GP with the aim of promoting good health and preventative measures.

An autism support group had been established.

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, EMIS, 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, 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, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. 100% of care plans had been reviewed in last year. 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 Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. A patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP personally summarised all new patients and reviewed their existing medication. We noted a culture among the GP and practice staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 15 and above and promoting the services offered by the Pennygate Foundation.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with mental health difficulties and 23 out of 26 had been offered and taken up the option of an annual physical health check in the year to date. Similar mechanisms of identifying 'at risk' groups were used for patients who had been identified as having chronic kidney disease and peripheral arterial disease. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 84%, which was better than others in the CCG area. There was a policy to offer reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was a similar mechanism of following up patients who did not attend was also used for other national screening programmes.

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 all immunisations was above the national average, and again there was a clear policy for following up non-attenders.

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Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the results of the National Patient Survey for 2014 and found that; 97% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG average 90%); 94% of respondents found the receptionists at the surgery helpful (CCG average: 90%) and 92% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG average 88%).

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and letters and without exception they 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 ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Many of the cards and letters praised the dedication and personal approach adopted by the GP and included comments about them working at weekends when the surgery was closed and opening the surgery in order to issue a prescription.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information remained so. The patient reception and waiting area was roomy which enabled patients who may have been queuing to speak with a receptionist to stand away from the reception area to help avoid overhearing conversations. There was a notice that informed patients that a private area was available for conversations should they require it.

Confidential paper waste was destroyed on site with a cross-cut shredder. Patient records held in paper format were stored securely and records held on computer were could only be accessed by the appropriate staff using their computer 'smart card'

Staff told us that 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 GP. The GP told us she would investigate these and any learning identified would be shared with staff.

The practice staff demonstrated a clear focus on meeting needs of vulnerable groups and in particular the 18% of the patient list who were of non-British birth, being predominantly Eastern European. Staff were mindful of the different health care systems that operated in their country of origin and told us how they took time to explain the workings of the NHS to them. They were particularly mindful of the propensity for this group of people to practice health care at home, buying drugs from the internet and self-medicating. We spoke with one patient who was of Eastern European origin who praised the work of the practice nurse and GP.

Staff took time to signpost patients in this vulnerable group to the Pennygate Foundation, as they had in place a number of initiatives and programs that were particularly applicable to migrant workers and their families.

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 64% of practice respondents said the GP involved them in care decisions and 75% felt the GP was good at explaining treatment and results

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

Good

Are services caring?

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 that 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. There was also a notice that promoted English classes for patients whose first language was not English.

Care plans were in place for some older people and all had been reviewed in agreement and with involvement of the patient.

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. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Staff told us that following bereavement the family were always invited into the surgery for a chat with the GP or nurse. Staff also signposted patients, carers and the bereaved to the Pennygate Foundation who were quipped to provide bereavement support and advice as well as advice on benefits and grants that might be available. They accompanied them to the centre to introduce them and 'break the ice' during this troubled time. Patients and carers that we spoke with and who had completed written comments cards and letters confirmed that after bereavement, the GP contacted them.

Notices in the patient waiting room and the patient website 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.

The patient waiting area had notices that directed patients to information on bereavement and support for carers.

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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements.

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 known as the Pennygate Patient Link.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services for example those of migrant workers. Although the practice demonstrated a clear and unambiguous approach to equality and diversity we noted that staff had not undertaken any formal training.

The practice had access to online and telephone translation services. The GP was able to speak Guajarati and understood Urdu and French. The practice was aware of the potential pitfalls in using a relative as a translator for patients who could not understand English and could provide translation services if required. However it was the experience of the GP that in most cases patients brought with them an English speaking friend and also used translation software on mobile telephones. The practice website had a translate facility.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was situated on the ground and first floors of the building with all services for patients on the first 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.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. There was no facility to make appointments on-line.

Appointments with the GP were available from 9 am to 11am and 3.30pm to 5.30 pm on weekdays. There was extended hours on one evening a week (variable). On Wednesday appointments with the GP were available from 9am to 11 am.

The surgery was open from 8.45 am to 6.30pm daily, excepting Wednesday when it closed at 3pm.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. We were told and we witnessed that patients were seen at very short notice. During the course of our inspection we saw two patients who had been called to make an appointment to see the GP and had been asked to come into the surgery straightaway. One was seen within 30 minutes of calling the surgery.

Another patient we spoke with recalled a time that there son was poorly on a Saturday afternoon and they had rang the GP at home to try and get appointment for first thing Monday. The GP wasn't at home but they left a message and that afternoon the doctor turned up at their house to see their son.

Longer appointments were also available for patients who needed them, for example who had difficulty communicating through profound deafness and those with long-term conditions. This also included appointments with the GP or nurse. Home visits were made to local care homes on a specific day each week, by the GP and to those patients who needed one. The practice nurse also visited the care homes to complete electrocardiography (the process of recording the electrical activity of the heart over a period of time) and ear syringing.

The practice's extended opening hours on one evening a week was particularly useful to patients with work commitments. This was confirmed by a survey that had

Good

Are services responsive to people's needs?

(for example, to feedback?)

been carried by the practice of patients who had used the extended hours surgery between April and June 2014. Of the 97 patients (78%) who responded to the survey, 90% said they had found the extended hours helpful.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system and posters were displayed in the patient waiting area. Further information was available in the practice 'Patient Information Booklet' and on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found they had been handled and dealt with appropriately.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on, for example all patients were now given a slip of paper with the specific telephone number to call for pathology and test results.

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. These values were clearly displayed in the practice patient information booklet and on the practice website as the Practice Charter. The practice vision and values included being treated individually and given courtesy and respect.

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. All of the policies and procedures we looked at had been reviewed annually, were up to date and relevant. The polices were available to staff in hard copy and on the practice computer system.

There was a clear leadership structure with named members of staff in lead roles. For example, there was the nurse was the lead for infection control and the GP was the lead for safeguarding. Staff members we spoke with 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.

We were aware that the GP worked alone and had a large patient list for a single handed practice. We were also aware that the practice did not have a dedicated practice manager and many tasks fell upon the GP. We talked at some length to the GP about these issues and the viability of the service going forward. Her dedication and competence re-assured us that this model worked for this GP and practice and we had no concerns as to its continuance. The GP had already addressed these issues and there were arrangements in place to ensure the practice continued to function as a result of her absence through prolonged illness or in the event of her death.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed its performance exceeded CCG and national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The GP told us about a local peer review system they took part in with neighbouring GP practices. This process gave the opportunity to measure its service against others and identify areas for improvement.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken, however we noted that they were not completed audit cycles and had not been subject to further audit and evaluation to measure their effectiveness.

The practice had arrangements for identifying, recording and managing risks. We saw the risk log, which addressed a wide range of potential issues, For example, we saw there was a policy that had related to the safety and suitability of the premises and the need for a regular maintenance program. We saw that the risk log was regularly discussed at team meetings 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 children's' toys in the waiting room were kept to a minimum to help manage the risk of infection.

The practice held regular governance meetings at which performance, quality and risks had been discussed.

Leadership, openness and transparency

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.

The GP was responsible for human resource policies and procedures. We reviewed a number of policies, including disciplinary procedures, induction policy, whistleblowing and public liability which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

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 patients through patient surveys and complaints received. We looked at the results of the annual GP patient survey of July 2014 and 88% of patients had said that they got an appointment that was convenient. We reviewed one complaint that concerned a lack of children's toys in the waiting room. We sat that the practice had responded in an appropriate manner and pointed out the risks of infection associated with children's toys in these circumstances.

The practice had a very active patient participation group, known as the Pennygate Patient Link (PPL), which had been active since 1994. Of the 197 members, 124 were described as white British, 23 were from the Baltic states, 27 Polish and 23 were described as other white. There was an active committee of ten patients who met regularly with the GP and nurse.

The PPL was a registered charity in its own right. The group ran a charity shop in Spalding town centre that was staffed by volunteers and raised finance for the benefit of needy patients. The group also ran bingo and quiz nights on a regular that were attended by 60-80 people. We spoke with the Chair of the PPL, a very experienced and well respected business man and former non-executive director of a NHS trust who gave us examples of the groups' charitable undertakings. These included providing transport for patients to attend hospital appointments and equipment for patients' homes that was not available from the NHS. The had also provided funding for a neurological consultant fee to lessen the waiting time for a patient. They provided relief in cases of hardship by providing vouchers to purchase food in supermarkets, having listened to representations from the GP.

The PPL had carried out surveys and we looked at the survey and results for the last two years. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings 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

The nurse told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that all staff had received an annual appraisal other than a recently employed member of staff. We spoke to a senior member of staff who told us that they conducted regular observational appraisal of reception staff, although it was not recorded. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings ensure the practice improved outcomes for patients.