Goldington Avenue Surgery

Quality Report

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Goldington Avenue Surgery on 28 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for each of the six population groups we looked at.

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.
- 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.
- All feedback from patients was positive saying they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice scored highest in the local CCG area in the National Patient Survey and was ranked in the top 5% nationally.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and 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.
- End of Life care was very good with learning shared within the locality to influence care at other practices.

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

The provider should:

Summary of findings

- Complete an infection control audit for the entire premises and implement actions identified in previous audits.

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 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. Reception staff were trained to carry out chaperone duties. A recent infection control audit had not been completed for the whole premises.

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. Patients with multiple conditions and those over the age of 75 years were offered dedicated longer appointments. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed 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. We received 26 completed comment cards and they were all very positive about the service experienced. Patients were complimentary about all levels of staff within the practice stating they are polite and friendly, empathetic and caring.

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. Feedback from patients indicated that there were no issues with

Summary of findings

access and booking appointments at the practice. They confirmed that they could see a doctor on the same day if they needed to 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 was shared 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. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from patients and worked with the patient participation group (PPG) to make improvements to the practice. Staff had received inductions, regular performance reviews and attended staff meetings. Staff told us that the practice was very supportive of training and that they had local specialist speakers attend the practice to discuss areas for example where referral trends had increased.

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.

Seventy-eight of the over 65 population had received a flu vaccination with 72% of eligible patients vaccinated against shingles.

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. The practice used a holistic recall programme for patients aged 75 years and over. This meant the patient was invited to one appointment for the all their chronic diseases resulting in one visit and one set of bloods taken.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice arranged a Saturday morning child flu clinic for two to four year olds. The practice does not normally open on a Saturday but offered this service to encourage more children to be vaccinated.

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 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. Ring-fenced appointments were available for students of the local university. The practice's extended opening hours was particularly useful to patients with work commitments. This was confirmed by a comment made by a patient stating they were happy that they could access the surgery as early as 7am.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. It had carried out annual health checks for people with a learning disability. 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. The practice has developed their safeguarding policy to reflect the coding used by other agencies and shared this best practice with others in the locality.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice made prompt referrals to appropriate services with adult mental health as the practice's highest referral category. 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

Summary of findings

organisations. It had a good working relationship with an onsite counsellor. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received 26 completed comments cards from patients. All the comments were complimentary and positive about the practice. Patients reported receiving excellent care and ease of access in relation to appointment booking.

The practice scored above the local CCG average in all areas of the National Patient Survey. For example 99% of patients surveyed found it easy to get through to the practice by phone and 98% described their overall experience as good. 95% said they would recommend this practice to someone new to the area.

We spoke with five patients who were all complimentary about the practice stating it to be clean and tidy, to have very good, friendly staff and that they were able to book an appointment when required.

Areas for improvement

Action the service SHOULD take to improve

- Complete an infection control audit for the entire premises and implement actions identified in previous audits.

Goldington Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a further CQC inspector.

Background to Goldington Avenue Surgery

Goldington Avenue Surgery provides a range of GP Services to people in Bedford. The practice population is predominantly white British but also serves patients from the minority ethnic groups mostly of eastern European backgrounds. It is classed as being in a low deprivation area. The practice has a list size of 9450 patients which is increasing by approximately 200-250 a year. It has a large student population as it is the surgery of choice for the University of Bedford.

The contract held by Goldington Avenue Surgery is a PMS contract. Personal Medical Services (PMS) agreements are locally agreed contracts between NHS England and a GP practice.

Clinical staff at the practice includes four GP partners, two salaried GPs and one trainee GP. There is a mixture of male and female GPs working both full and part-time hours. There are four practice nurses and one health care assistant. The practice also has a number of reception and administration staff led by the practice manager.

The practice has recently been reaccredited as a training practice and will be receiving medical students from Cambridge University.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing low risk. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice has opted out of providing out-of-hours services. This service is provided by BEDDOC and can be accessed by telephoning them direct, the number can be obtained from the practice answerphone or via the NHS 111 service.

Why we carried out this inspection

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

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

Please note 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.

Detailed findings

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 28 January 2015. During our visit we spoke with nine staff members including GPs, nursing staff, the practice manager, reception and admin staff and spoke with five patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff informed us of an incident of inappropriate behaviour from a patient, we saw that this had been reported and appropriate actions taken.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were discussed as they arose at clinical meetings and there was a standing item on the practice meeting agenda every 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. 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.

We saw completed incident forms that staff had sent to the practice manager. We were shown the system used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of failure of one of the vaccine fridges to maintain the correct temperature. We also saw evidence that staff learning had been identified as a result of a complaint and appropriate actions taken to implement additional training.

National patient safety alerts were disseminated by the practice manager via a computer alert to practice staff. The senior practice nurse also took responsibility for ensuring that the nursing team were aware of alerts relevant to their role. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the monthly practice meetings and the three monthly nurses' meeting 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. 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 and document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible within the safeguarding policies which were available online for all staff.

The practice had developed it's safeguarding policy to make use of coding used by other agencies this was then shared with other practices within the locality.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained to a higher level and could demonstrate they had the necessary training to enable them to fulfil this role. Most of the staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. Those who didn't know all said they would escalate concerns with a senior staff member.

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, patients with caring responsibilities and those with learning difficulties.

There was a chaperone policy and a notice advising this, which was visible at the reception desk (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care

assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. The medicines cupboards were locked but the keys remained in the locks and therefore the practice staff could not be assured that medicines were only accessible to authorised staff. After discussion with the practice staff they assured us that they would change this practise. 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.

The nurses 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 nurses had received appropriate training to administer vaccines.

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.

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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit in the last six months however this was limited to the domestic room and one consulting room; it did not cover the whole practice. A CCG infection control review in 2013 noted that the hand wash sink and carpeted area in the HCA room were not meeting specifications; we observed that these had not been changed.

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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

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 of December 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example equipment used for the treatment of asthma, diagnostic machines and blood pressure measuring devices were all calibrated in June 2014.

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). Some of the reception staff who had worked for the practice for many years had not had a DBS check, this had been risk assessed and a decision made that it was not required for these staff

members. Two of these reception staff members performed chaperone duties which would require them to have a DBS check. The provider wrote to us following our inspection to confirm that the two staff members had since had DBS checks undertaken. 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. There was also an arrangement in place for no more than one member of each staff group to take scheduled leave at the same time.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had recognised that they did not have enough practice nurses to meet demand and had subsequently recruited new staff and increased the hours of other existing nursing staff to fulfil this role resulting in a reduction in waiting times for appointments to see a nurse.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. An external company had been employed to carry out a health and safety audit in March 2014. Recommendations on the health and safety policy and staff training had all been implemented.

There was no formal risk log at the practice but there was a system for reporting identified risks which were then discussed and reviewed at practice meetings and any learning points shared with appropriate staff. We saw copies of completed risk reporting forms with actions identified and documented to mitigate future risks.

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 and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies 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 loss of premises, computer system failure, loss of telephony, unexpected staff shortages and loss of utilities. The practice manager advised in the event of loss of the telephony system there was a mobile phone for direct access by local care homes.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. We saw that the fire alarm system and been inspected in September 2014 and was fully operational. All fire equipment had been inspected in June 2014.Records showed that staff were up to date with fire training.

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. One of the GPs regularly attended meetings with the local CCG and shared information at the practice clinical meetings. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We saw that an audit of patients receiving oral nutritional supplements had been completed and highlighted prescribing issues, changes had been made resulting in a reduction of prescribing costs. 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 end of life care and hypertension. They worked closely with the practice nurses who supported this work. Clinical staff we spoke with described an open culture within the practice and were able to ask for and provide colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. The clinical meeting minutes confirmed that this happened.

We saw evidence that the local medicines management team visits the practice to discuss prescribing charges and medicines audits. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. Patients with multiple conditions and those over the age of 75 years are offered dedicated longer appointments. We were shown the process the practice used to review patients recently discharged from hospital.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for referrals. The practice also invited local specialist speakers to attend clinical meetings to discuss when referral trends had increased. The practice manager supplies the clinical staff with monthly referral rate data across the practice.

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 are involved in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits. We saw that there had been a recent review of asthma patients within the practice.

The practice showed us several clinical audits that had been undertaken in the last year. We saw that there had been an audit on dementia care which resulted in a review of four patients receiving anti-psychotic medication with one patient having this medication withdrawn. We also saw an audit of patients with Chronic Obstructive Pulmonary Disease (COPD). As a result of the audit, changes had been made to steroid prescribing. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For

Good

Are services effective?

(for example, treatment is effective)

example, at the time of our inspection patients with asthma were being invited to the practice for an annual review. The practice is above the local CCG average for all areas of QOF except for the care of Mental Health.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a 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 for example the system flags medication interactions. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. These were attended by the lead GP for end of life care within the practice, the practice manager, Macmillan and community nurses. All patients on the register were discussed and medications were reviewed. Tasks were allocated to the patients' GP as a result of the meeting to influence their care. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register to include those with cancer, Chronic Obstructive Pulmonary Disease (COPD), heart conditions and those over the age of 100 years. In the past month there had been an increase of seven patients added to the register. The practice manager also held a monthly meeting with GPs to discuss patients that had died. The end of life care for these patients was reviewed taking into consideration recent hospital admissions and if anything in the patient care plans had been missed. The learning was shared with all GPs in the practice.

The practice used a holistic recall programme for patients aged 75 years and over. This meant the patient was invited to one appointment for the all their chronic diseases resulting in one visit and one set of bloods taken.

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 medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with all having particular areas of interest including prescribing, commissioning, minor surgery and family planning. 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 interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the practice nurses had received a recent update in the care of COPD patients. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. They had daily debriefing sessions, weekly tutorials and attended the clinical meetings. We received positive feedback from the trainee we spoke with.

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, cervical screening and phlebotomy. Those with

Good

Are services effective?

(for example, treatment is effective)

extended roles for example seeing patients with long-term conditions such as asthma and COPD were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the NHS 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 who 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 and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly 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 community nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice had an onsite counselling service and patients who may benefit from the support of an advocate were made aware of the POhWER advocacy service, a charitable organisation that provides information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion.

The community midwife held a clinic at the practice once a week.

Information sharing

The practice used several electronic systems to communicate with other providers. Electronic systems were in place for making referrals 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.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. This was done using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record SystmOne 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 the 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, the Children Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe examples of when they would implement 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. A health facilitator is used to support the patient and carers involvement in care planning. 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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have

Good

Are services effective?

(for example, treatment is effective)

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 were also prompts on SystmOne to aid staff in using Gillick competencies when assessing children.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, 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.

Health promotion and prevention

It was practice policy to offer a health check with a GP to all new patients registering with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing for example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that they had exceeded the number of health checks required for the year 2013/14 with 346 health checks completed. As the GPs did the new patient health checks reviews of medications and medical conditions were done at the same time.

The practice had numerous ways of identifying patients who needed additional support, one of these was by the GP at the new patient health check and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and offered an annual physical health check. The practice also actively promoted a stop smoking campaign each new year. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 80%, which was in line with others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. The reception staff were responsible for following up patients who did not attend screening.

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 average for the CCG, and again there was a clear policy for following up non-attenders by the reception staff. Seventy-eight percent of the over 65 population had received a flu vaccination with 72% of eligible patients vaccinated against shingles. The practice also arranged a Saturday morning child flu clinic for two to four year olds. The practice does not normally open on a Saturday but offered this service to encourage more children to be vaccinated. As a result 55% of this age group received a vaccination. Eligible patients were also offered Pneumococcal vaccinations this included at risk patients for example those with COPD who were actively contacted if they had not received the vaccination.

We also saw health promotion information displayed in the waiting room providing seasonal health advice re flu and available vaccinations as well as travel vaccines and child immunisations.

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 and patient satisfaction questionnaires as part of the friends and family test.

The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey from 2014 showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at listening to them with 97% saying the same of the nurse. 91% say the GP and 98% say the last nurse they saw or spoke to was good at giving them enough time

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and they were all very positive about the service experienced. Patients were complimentary about all levels of staff within the practice stating they are polite and friendly, empathetic and caring. There were no concerns expressed about accessing appointments. There were no negative comments on any of the completed cards. We also spoke with five patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and found the staff to be very good and their dignity and privacy was respected.

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 / 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. The waiting area was a separate room visible through glass doors and a window from the reception area which helped keep patient information private.

In response to suggestions from the Patient Participation Group extra seating had been provided in the waiting room. Also there was a reduction in unnecessary reading material.

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 the practice manager who would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

We were told that patients who attend the practice frequently are well known to all the staff who were then able to promptly identify any changes in the patient's behaviour or circumstances.

Care planning and involvement in decisions about care and treatment

The patient survey from 2014 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 91% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above average when compared to other practices in the local CCG area.

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 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. Some

of the practice staff have British Sign Language skills, in addition a number of the admin staff have had a basic BSL training session to support communication. The practice also used the SignTranslate online service for their deaf patients when a translator was not available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, the national survey results from 2014 showed that 92% of respondents say the last GP they saw or spoke to was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. One comment card stated that all of their needs had always been responded to with the right care and treatment.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. There was a wide variety of health promotion and information leaflets available for patients to read and takeaway. This included information on long term conditions such as diabetes and cancer; pregnancy and sexual health advice and travel vaccinations. There was also seasonal information giving advice on managing health through the winter months and staying warm.

The practice's computer system alerted GPs if a patient was also a carer. There was a carer's noticeboard in the waiting room with details of a local carer's organisation and separate café. There was a carers' grant leaflet and a notice advising carers how to identify themselves to the practice.

Staff told us that if families had suffered a bereavement, the practice would receive a notification of death. As the community is well known to the staff they tend to know the families and identify them when they come into the surgery. A Primary Care counsellor commissioned by the local CCG worked on the premises so bereaved patients could use the service or they could be referred to CRUSE, a free, confidential service providing support to the bereaved.

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 practice had a large student population providing GP services to the students of University of Bedfordshire, Bedford campus. These services were provided from the practice, with ring-fenced appointments set aside for students, although they could book into any available appointment time. The practice was attempting to arrange a cross campus campaign to highlight GP services in partnership with the Luton campus sites and the GP practice in Luton that provided these services.

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 that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population, for example the practice was sharing best practice on end of life care with other services in the area. The practice manager was an active member of the local Practice Forum attending regular meetings.

The practice generally had good feedback from the patient participation group there were no suggestions for improvements and to the way it delivered services.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice population was predominately white British with a large student population. It also provided a service to patients residing in care and nursing homes.

The practice had access to online and telephone translation services. They also used an online signing translation service.

The practice provided equality and diversity training through e-learning. All staff completed the equality and diversity training every three years.

The premises and services had been adapted to meet the needs of patient with disabilities. Access to the building was via ramps and wide doors with automatic open buttons. There was a stair lift available for patients who had difficulty using the stairs. The practice had consulting rooms on the ground and first floors; we saw that the staff aimed to ensure that the downstairs consulting rooms were used for patients with mobility issues. There was a hearing induction loop in the reception area to aid those patients with hearing difficulties. 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

Morning appointments were available from 7.10am -11.30am three days a week and 8.40am to 11.30am two days a week. Afternoon appointments started at 3.30pm every day until 6pm three days a week and 6.40pm two days a week. Urgent appointments were available on the day of request and patients could book in advance if required.

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 and cancel appointments through the website. 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. Patients could either telephone the out of hours service provided by BEDDOC direct or access it via the NHS 111 service.

Longer appointments were also available for patients who needed them and those with long-term conditions. The reception staff had written guidance on which conditions may require a longer appointment slot. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one. The practice was not aligned to any specific care or nursing homes. Patient choice allowed the patient to decide which practice they would like to be registered with. There was a Complex Care Team within the Bedford locality who contacted the local

Good

Are services responsive to people's needs?

(for example, to feedback?)

care and nursing homes and dealt with any issues regarding minor illnesses and medication queries. Anything else was then passed to the practice for assessment and response where a decision was made to make a home visit dependant on need.

Feedback from patients indicated that there were no issues with access and booking appointments at the practice. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. A patient commented that they had never had to wait more than 24 hours for an appointment.

The practice's extended opening hours was particularly useful to patients with work commitments. This was confirmed by a comment made by a patient stating they were happy that they could access the surgery as early as 7am.

Another patient completed a comment card stating they had contacted the practice from their holiday destination without their medication and the GP faxed details of her medication to the local pharmacy; the patient was pleased with the service they had received.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system; there were complaint leaflets available in the waiting room and information in the practice leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 12 complaints received in the last 12 months and found that these had been satisfactorily handled. Apologies had been given when appropriate and explanations of findings were given when the complaint had not been upheld. One complaint had been referred to the Ombudsman and had not been upheld.

The practice reviewed complaints every six months 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. One complaint had been from a patient who was distressed at being seen by a medical student, the practice had now implemented additional communication to ensure patients are aware when they have an appointment with a student.

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 did not have a business plan or vision documented, but staff we spoke with demonstrated that they aim to raise the level of care for patients whilst also being financially aware therefore bringing services closer to patients in an efficient way.

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 a number of these policies and procedures and noted there was a system in place to inform staff when changes or updates had been made. All the policies and procedures we looked at had been reviewed and were up to date.

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

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 regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. In addition the practice manager sent a monthly Management Pack to all the clinicians detailing information on the latest QOF data with individual performance and areas that needed to be reviewed.

The practice manager was an active member of the local CCG Practice Forum which met ten times a year to discuss local needs and service improvements. We saw evidence that good practice developed in the surgery was shared with others at these meetings.

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. There has been a recent audit on dementia care and the review of medication for these patients. There was also a completed audit on the care of patients with Chronic Obstructive Pulmonary Disease.

The practice had arrangements for identifying, recording and managing risks. There was not a formal risk log in the practice but minutes from the clinical meetings showed that risks were discussed and any actions were communicated to staff.

The practice held monthly practice meetings that incorporated governance. There was a yearly plan with agenda items to discuss. We looked at minutes from the last three meetings and found that performance, quality and risks had been reviewed.

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. The reception staff were not involved in the team meetings and on discussion this was clear it was at their request not to be included. They were able to feed into the meetings via the Practice Manager and the open culture within the practice enabled them to approach any staff member with concerns they may have.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example Training and Development, Whistleblowing and Recruitment. Staff we spoke with knew where to find these policies if required and all were available online on individuals desktops.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. Patients can complete the Friends and Family test online via the website or complete a comment slip available in the waiting room. There was very little negative feedback from patients. We saw the results of the Friends and Family Test which showed that the majority of respondents could not identify anything to improve the services and that satisfaction was high. The national survey from 2014 showed that 99% of respondents found it easy to get through to this surgery by

Are services well-led?

Good

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

phone and 99% found the reception staff to be helpful. Whilst 99% of patients stated they were able to get an appointment to see or speak to someone the last time they tried the practice staff had identified that patients were waiting longer to get an appointment with the nursing staff. In response to this the practice has increased its nursing staff capacity and had noticed an improvement in access for the patients.

The practice had a patient participation group (PPG), a group of patients registered with the surgery who have no medical training but had an interest in the services provided, which was currently led by the practice but the aim was for the group to be more independent in the coming year. We saw feedback from the meetings held and actions that had been taken by the practice; for example some additional chairs without arms were purchased for the waiting area and requests had been made by the practice manager to the local authority for a dropped kerb outside the premises to improve access for wheelchair users and parents with pushchairs. This has now been completed.

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 electronically on any computer within the practice.

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 local specialist speakers attend the practice to discuss areas for example where referral trends had increased.

The practice was a GP training practice and at the time of the inspection had one GP trainee (an experienced hospital doctor who is gaining experience to enter General Practice). They also had first and second year medical students on placement at certain times.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. Learning from events are acted on as soon as possible for example we noted that there had been a failure in maintaining the correct fridge temperature and appropriate action had been taken to maintain the viability of the vaccines held. Minutes from meetings showed that all significant events were reviewed six monthly to identify any trends.