Pinfold Medical Practice

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 Pinfold Medical Practice on 20 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments and telephone consultations were available on the same day but not necessarily with patients having a choice of GP.
- The practice made good use of audits to improve patient care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients which it acted on.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. 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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and 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

Summary of findings

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 and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice carried out proactive succession planning.

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. The practice offered proactive, personalised care to meet the needs of the older people in its population. It had developed a proactive care template which it used to ensure patients' needs were assessed and treated appropriately. This included people requiring end of life care. Patients with complex needs were discussed with members of the multidisciplinary teams to ensure appropriate care and support was provided. It had a register of patients who were house bound. Their care was reviewed at least annually and a GP made regular visits to them. The practice provided care and support to the residents of two care homes with two visits each week to each home. The GP took summary care records with them to ensure continuity of care. Patients were offered flu and shingles vaccinations with an active recall system if patients missed them.

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 were supported by nurse specialists who visit the practice regularly. There were GP leads for diabetes, asthma, COPD, mental health, CKD and cardio vascular diseases. The practice provided a full anticoagulation service and improving the quality of that was a main focus.

The practice had developed a system it called integrated recall which was a streamlined approach to identifying patients who needed annual checks, organising these in a timely and effective way and ensuring all the results were available when the patient had their annual review with the GP.

The practice kept a register of patients with more complex needs including those requiring end of life care. The named GP worked with other health and care professionals to ensure care and support was provided. Relevant information was made available to out of hours providers for those patients receiving end of life care to ensure appropriate treatment and support.

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 looked after children and children at risk. The practice monitored children and young people who had a high number of A&E attendances and Out of Hours service use. The practice offered postnatal and six-week

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baby checks and a full in-house immunisation and vaccination service. The practice had an emergency care nurse and duty doctor and was able to provide on the day appointments which was particularly well used by parents with sick children.

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). Appointments and repeat prescriptions could be arranged online. The first appointment each day was 8.10am and the practice was open till 8pm on Monday evenings. Daily telephone consultations were available to help provide minimal disruption to working people. A full contraceptive service including on the day evening appointments with a specialist nurse was provided.

Flu vaccination clinics were provided on a Saturday to enable working people to attend or to bring an elderly friend or relative without disruption. A fully trained travel nurse was available to advise patients about travel vaccinations.

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 had identified those of its patients who had a learning disability. These patients were offered annual health check and longer appointments. The practice was working closely with the CCG on a scheme for homeless people. People could use the practice without having a permanent address and were offered help and care with mental and physical health, vaccinations and where appropriate, substance misuse. It had also developed a good working relationship with a local project providing support for homeless people.

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 and outside normal working 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). The practice had a register of people with mental illness which was reviewed annually and patients were offered an annual physical health check with a nurse which their GP would encourage them to attend. The

Summary of findings

practice undertook dementia screening and offered check-ups to carers. It worked closely with pharmacists to ensure that patients with memory impairment had their medication prescribed safely using dossett boxes where appropriate.

There was an in-house mental health practitioner who provided counselling and the practice also worked closely with secondary care mental health services including the CRISIS team and community psychiatric nurses. The practice provided information to patients experiencing poor mental health about support groups and voluntary organisations. This was also on the practice website.

Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with nine patients including two members of the patient participation group (PPG). The PPG is a group of patients who work with the practice to highlight patient concerns and work with it to improve the quality of care and services.

We received 37 comment cards written by patients. The majority of the comments were very positive. Patients described staff as friendly and very helpful and said that they were listened to and treated with respect and care. Several said they had recommended the practice to friends and relatives. There were several comments about recent improvements with booking appointments.

The PPG had worked with the practice to design patient surveys, the last of which took place in the autumn of 2013. This received 433 responses which helped the practice identify areas of concern, for example, the need to improve the premises and to explain how the practice appointment system worked. Subsequently, the PPG added a question to the Friends and Family test which asked patients to 'name one thing we could do to improve the service that we offer'. The practice has acted on the main areas suggested for improvement, which included providing a local telephone number, a simpler appointment system and more receptionists at peak times. 92% of patients asked said they would definitely recommend the practice to their friends and family. This was mirrored in the results from the national GP patient survey about the practice which showed that 90% of respondents said the last GP they saw or spoke with was good at involving them in decisions about their care but 40% expressed frustration with the appointment and telephone system.

We also spoke with representatives from care homes where residents were registered with the practice. They told us they were generally satisfied with the care and service their residents received.

Pinfold Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector and the team included a GP, a GP practice manager and another CQC inspector.

Background to Pinfold Medical Practice

Pinfold Medical Practice is a GP practice in the town of Loughborough in Leicestershire. It provides a range of primary medical services to approximately 10,700 patients. The services are provided by seven GP partners, one salaried GP and one long-term locum GP, three practice nurses (including a nurse practitioner) and three healthcare support workers. They are supported by a management team and reception and administration staff. The practice provides 48 GP sessions each week. There are four male GPs and five female GPs. The practice is a training practice. It has registrars who are fully qualified doctors who are training to work in general practice and also medical students who spend some time learning about general practice.

The practice is supported by local community health teams which provide maternity and health visitor services.

The practice occupies part of Loughborough Medical Centre, which is a single-storey building with parking available including designated disabled bays. There are automatic doors and a wheelchair available for patient use.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services. It works within West Leicestershire Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local services. We reviewed information from the CCG and Public Health England which showed that the practice population had deprivation levels similar to the average in England.

The practice is open between 8am and 8pm on Monday and 8am to 6.30pm Tuesday to Friday. (Closed 12.30pm to 1.30pm on Tuesdays.) Appointments are available between 8.10am and 5.30pm. (7.45 on Mondays). The practice has opted out of providing an out of hours service when the surgery is closed. This is provided by the Leicester, Leicestershire and Rutland out of hours service which covers the area and can be accessed through the NHS 111 number.

Why we carried out this inspection

We carried out a planned comprehensive inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act and to provide a rating for the service under the Care Act 2014.

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?

Detailed findings

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 20 May 2015. During our visit we spoke with a range of staff including GPs, nurses, healthcare assistants, reception and clerical staff and members of the management team. We reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) for completion before the inspection took place. We spoke with patients and representatives who used the service, including two members of the Patient Participation Group (PPG). The PPG includes representatives from various patient groups who work with practice staff to improve the service and quality of care. We observed how people were being cared for and talked with patients, carers and/or family members.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to help identify risks and improve patient safety. This included 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. For example, it was thought that a patient had been given an incorrect vaccination. Further investigation revealed that the batch number had been noted and this showed that the correct vaccination had been given. Staff were reminded to ensure they made correct entries in patient notes and to continue to check and note batch numbers when giving vaccinations.

We reviewed safety records, 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. We reviewed records of significant events that had occurred during the previous 18 months and saw this system was followed appropriately. We saw evidence that significant events were regularly discussed at staff meetings and that the practice regularly reviewed actions and learning from significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with all relevant staff. Staff, including receptionists, administrators and nursing staff told us they knew how to report a significant incident and that they felt encouraged to do this.

Staff completed incident forms from the practice intranet and sent them to the patient services manager. They showed us the system on the practice shared drive used to manage and monitor incidents. We tracked several incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that learning had been shared. We looked at an incident where a patient had complained about the attitude of remember of reception staff. Further investigation showed that this was caused by a misunderstanding but the member of staff involved reviewed what had happened and shared the issue with their colleagues. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated according to a safety alerts protocol which covered drug and medical device alerts. The alerts were received by three members of staff. These were forwarded to GPs and nursing staff and a copy of the alert was placed on the staff noticeboard. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. They also told us alerts were discussed at GP and practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people 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 safeguarding concerns and how to contact the relevant agencies in and out of normal working hours. Contact details were easily accessible.

The practice had a GP lead in safeguarding vulnerable adults and children, who had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil this role. All staff we spoke with were aware of who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans and looked after children. Staff described a situation to us where they had raised a concern about a child's safety and what action was taken which included informing social services. The practice monitored

frequent attendance of children and young people at accident and emergency departments and the out of hours service to identify any potential safeguarding issues. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including regular meetings with health visitors.

There was a chaperone policy which was explained in plain English on the practice web site and on posters on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, health care assistants and receptionists had received appropriate training. Staff understood their responsibilities when acting as chaperones. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or with vulnerable adults.)

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

We found that there were not robust systems in place to check that emergency medicines and equipment were replaced when required. It was not clear what equipment or medicines were required and what should be done if anything appeared to be missing. We told the practice what we had found and they decided to treat this as a significant incident. The practice has since provided evidence that it has clarified what is required and emphasised to the staff involved what their responsibilities were for checking the supplies.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance. They were tracked through the practice and kept securely at all times. The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) The prescriptions were marked and patients signed for them when collecting.

We saw records for reviewing the prescribing of drugs such as antibiotics, hypnotics, sedatives and anti-psychotics within the practice. We saw an audit into anti-psychotics prescribing for patients with dementia using CCG guidelines which was discussed at a clinician's meeting and which emphasised the need for annual reviews of dosage.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in line with national guidance. Computer systems showed alerts for blood tests and other checks and how they were acted upon. The practice had developed a pro-active recall system to ensure patients were contacted to help ensure they attended for relevant tests.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. Health care assistants administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and health care assistants had received appropriate training and been assessed as competent to administer the medicines referred to. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

The practice held limited stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). There were procedures in place that set out how they were managed which were being followed by the practice staff. For example, controlled drugs were stored in a safe within a locked room with limited access.

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

Good

Are services safe?

always found the practice clean and had no concerns about cleanliness or infection control. Cleaning was provided by the landlord of the building but the practice had arranged for the cleaners to have training in basic infection control. We saw evidence of regular checks by the practice to ensure the premises were kept clean.

The practice had a lead for infection control who had been trained to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training and annual updates about infection control specific to their role. We saw evidence that the lead had carried out audits on a six-monthly basis and that any improvements identified for action were completed. Minutes of practice meetings showed that any issues about infection control were discussed in the regular health and safety slot.

An infection control policy and supporting procedures were available which enabled staff to plan and implement measures to control infection. For example, there were detailed instructions for cleaning the treatment room used for minor surgery before and after use. We saw staff using personal protective equipment including disposable gloves and aprons. Staff knew the protocol to follow if there was a needle stick 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 owners of the building arranged checks for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice had records of regular checks being carried out to reduce the risk of infection to staff and patients.

Equipment

Staff 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 servicing schedules and equipment maintenance logs that confirmed this. All portable electrical equipment was routinely tested by the owner of the building. The practice had a system for checking to ensure this was done as required and showed us the logs they kept. We saw evidence of calibration of relevant equipment, for example, weighing scales, spirometers, blood pressure measuring devices (including 24hr monitors).

Staffing and recruitment

The practice had a recruitment policy that set out the procedures it followed when recruiting clinical and non-clinical staff. 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 the appropriate checks through the Disclosure and Barring Service (DBS). (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had risk assessments in place for those staff roles where it had assessed DBS checks were not needed.

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 to ensure that enough staff were on duty. Annual leave was managed to ensure that sufficient staff remained at work.

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 signed up to an NHS initiative called 'Productive General Practice' which was designed to help GPs continue to deliver high quality care while meeting increasing levels of demand and expectation. This had helped the practice map demand to capacity and ensure they had correct staffing levels and skills mix wherever possible. One result of this was the employment of an additional receptionist specifically to work early in the morning when patients were phoning to make appointments.

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 regular checks of the building, the environment, medicines management, staffing, and dealing with emergencies and equipment. The practice also had a health and safety policy. Health and

Good

Are services safe?

safety information was displayed for staff to see and there was an identified health and safety representative. There was also a health and safety slot at the regular practice meetings.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service were included on the log. We saw an example of this (accommodation damage such as flooding or vandalism) and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at some practice meetings.

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 in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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. However, we found that there was not a sufficiently robust system in place to ensure that emergency drugs and equipment kept at the practice and in the GP's home visit bags were available in the correct amounts. Following our visit, the practice provided evidence that this issue has been reviewed and systems put into place to check that all necessary emergency medicines and equipment were available and within their expiry date.

A detailed service continuity plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. Anything related to the premises, for example, heating would be referred to the owners of the building. The plan was reviewed annually or whenever a new issue was identified.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that this guidance was accessible on-line for all staff.

We discussed with the practice manager, GPs and nursing staff how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was discussed. Any implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and were in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. A specialist diabetes nurse attended the practice on a weekly basis and saw patients with sub-optimal results. They also dealt with diabetic patients who needed advice about fasting during Ramadan or when travelling. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened. The practice was also supported by a specialist Chronic Obstructive Pulmonary Disease (COPD) nurse from the CCG.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. The practice had developed a proactive care template for patients most at risk of unplanned hospital admissions, for patients who had problems such as pressure sores, and for those requiring end of life care. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that their needs were continuing to be met.

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

Information about people's care and treatment and outcomes was routinely collected, monitored and used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information collected was then collated by administrative staff to support the practice to carry out clinical audits.

The practice showed us nine clinical audits that had been undertaken during the last three years. Five of these were completed audits where the practice was able to demonstrate the changes to treatment or care when needed. The practice was partway through an audit related to stroke prevention in patients with atrial fibrillation (AF). As a result the practice developed a series of interventions to reduce stroke risk in the patient population. This included additional training for practice staff and developing a new protocol for reviewing patients at risk of developing a stroke. The practice intended to initiate further data collection at the end of 2015 to measure the effectiveness of the new protocols.

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

Good

Are services effective?

(for example, treatment is effective)

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 antipsychotic drugs in patients with dementia. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines often during the annual review of patients in care homes to consider whether there could be any reduction in the dosage.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.4% of the total QOF target in 2014, which was above the national average of 92.4%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and hypertension QOF indicators was above the national average.

The practice continually monitored its performance to ensure it was in line with national or CCG figures.

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.

The practice's prescribing rates were also slightly better than the national average. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check that patients receiving repeat prescriptions had been reviewed by a GP. They also checked 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 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 practice had made use of the gold standards framework for end of life care. It had a register of patients who needed palliative care and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as people with learning disabilities, mental health problems and homeless people. Structured annual reviews were also undertaken for people with long term conditions such as diabetes, COPD (chronic obstructive pulmonary disease), and AF.

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

Effective staffing

The practice employed medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with several having additional training and being able to provide treatment and advice with musculoskeletal problems, family planning, minor surgery, and ear nose and throat problems (ENT). All GPs were up to date with their yearly continuing professional development requirements and either had 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 provided training and funding for relevant courses. The practice was a training practice which meant that both medical students and GP registrars (these are qualified

Good

Are services effective?

(for example, treatment is effective)

doctors who are training to be GPs) worked at the practice. We spoke with the registrars who told us that they were debriefed on a daily basis by the duty doctor and that they felt they were challenged, supported and valued by the practice.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on the administration of vaccines, cervical cytology, and taking blood samples. Those with extended roles for example seeing patients with long-term conditions such as asthma, COPD, diabetes and AF were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where any poor performance had been identified appropriate action had been taken to manage this.

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 (including discharge summaries) from the local hospital and out-of-hours GP services and the 111 service both electronically and by post. The practice had a protocol outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. 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.

Emergency hospital admission rates for the practice were the similar to the national average.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs, for example, those with end of life care needs. A member of the administrative team kept the register of all of these patients which included any issues the GP looking after that patient wanted to raise or if the patient was stable. These meetings were attended by district nurses, the virtual ward sister (who can organise social care when needed) and Macmillan nurses, as well as practice staff. Decisions about care planning were documented in a shared care record. Staff felt this system worked well. Proactive care plans developed by the practice, were in place for patients with complex needs and shared with other health and social care workers as appropriate.

There was regular attendance at the practice by the midwife, COPD, diabetes, and heart failure specialist nurses, and mental health nurse and a drug and alcohol abuse worker which helped the practice support patients with complex needs.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system (EMIS) with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had also signed up to the electronic Summary Care Record. (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 to coordinate, document and manage patients' care. All staff were fully trained on the system and followed a set protocol which ensured information was forwarded to GPs. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that there were regular checks to ensure the completeness of these records.

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 relating to the legislation. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it giving relevant examples.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care

Good

Are services effective?

(for example, treatment is effective)

plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if necessary) and had a section stating the patient's preferences for treatment and decisions. Staff were able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice protocol about consent to treatment. This emphasised the importance of giving patients sufficient information about the benefits and risks of any treatment before seeking consent. It was also clear about different kinds of consent and where consent should be documented in the electronic patient notes.

Health promotion and prevention

All new patients registering that the practice were offered a health check. Any health concerns were noted and a GP tasked to follow this up in a timely way. We noted that GPs and nursing staff used their contact with patients to help improve health and well-being. For example, patients who smoked were offered smoking cessation advice.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had carried out an audit of the take-up of national cancer screening programmes which was below the national average. It identified that this was particularly the case amongst patients from ethnic minority backgrounds. As a result all staff were trained about the screening programmes and encouraged to promote these within the community. Several staff spoke community languages.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance.

- Flu vaccination rates for people over 65 were 77.12%, and at risk groups 59.71%. These were slightly above national averages.
- Childhood immunisation rates for the vaccinations given to under twos and five year olds were comparable to national averages.

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 (2015), and a survey of 433 patients undertaken by the practice's patient participation group (PPG). (a PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.)

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89 %.
- 91% said the GP gave them enough time compared to the CCG average of 86% and national average of 87 %.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- Patients reported similar levels of satisfaction with nurses at the practice

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were professional, welcoming, friendly and easy to talk to. They said staff were caring and treated them with dignity and respect. Three patients were positive about their experience at the practice but less positive about the difficulties they had experienced getting an appointment. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice. Several told us they would and indeed had recommended the practice to other people.

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 any examinations and treatments.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments. The practice switchboard was separately located to the reception area which helped keep patient information private. There was some distance between the seating area and the reception desk which helped prevent conversations being overheard.

There were notices in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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:

- 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%.

Patients we spoke with on the day of our inspection told us that they felt involved in making decisions 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 choices of treatment. Patient feedback on the comment cards we received was also positive about these matters.

Staff told us that interpretation services were available for patients whose first language was not English. We saw notices in the reception areas informing patents this service was available. Several staff spoke community languages and this was useful when patients phoned or called in. They did not act as interpreters.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the support provided by the practice and rated it well in this area. For example:

Good

Are services caring?

- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 90%.

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 were friendly and compassionate when they needed help and provided support when required.

Notices in the patient waiting room and information on the practice website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer so they could be directed to appropriate support services.

Staff told us that if patients had suffered bereavement, their usual GP telephoned them. This call was either followed by a patient consultation at a flexible time and location or by giving them advice about how to find appropriate support.

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. For example, all staff had been trained about National Cancer screening programmes and were encouraged to give information about these in the practice and within the ethnic minority communities in the locality.

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 the practice had discussed this and recognise the importance of involvement to improve services.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) (this is a group of patients who work with the practice to improve services and the quality of care). This included the introduction of a local telephone number and changes to the appointment system to make it simpler and provide more on the day appointments with GPs and the nurse practitioner.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. Patients with mental health issues were offered appointments when the practice was relatively quiet to reduce any stress involved. People who were homeless could register without giving a permanent address. The practice worked closely with a local project working with homeless people. A significant number of the practice population did not have English as their first language. The practice could arrange interpreters and also access online and telephone interpretation services.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level and the doors automatic. There were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. The practice had a wheelchair available for patients to use.

Patients could choose to see a male or female doctor.

The practice provided equality and diversity training at induction and through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 8am to 8pm on Monday and from 8am to 6.30pm Tuesday to Friday. Appointments were generally available from 30 minutes after the surgery opened and 30 minutes before it closed. There was a duty doctor every day who saw patients who needed an urgent appointment, took urgent telephone calls, and made emergency visits. They also supported the GP registrars with a daily debriefing session.

Comprehensive information was available to patients about appointments, including urgent appointments and home visits on the practice website and in the patient information leaflet. Appointments could be booked in person, by phone and online. When the practice was closed, an answerphone message gave advice and relevant telephone numbers, depending on the circumstances. This included the out-of-hours service.

Longer appointments were also available for any patient who requested them. The duty doctor telephoned patients requesting home visits to ensure this was appropriate. A GP visited two local care homes twice a week.

The patient survey information we reviewed showed patients has not been very satisfied with how they could make appointments. This did not take into account recent changes in the appointment system. Patients we spoke with told us there have been problems in the past but it was now much easier to get an appointment and the phone system had improved. They confirmed that they could often see a doctor on the same day although this might not be their GP of choice. Routine appointments were available for booking three weeks in advance.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 Patient Services Manager handled all complaints in the practice.

Information was available to help patients understand the complaints system. There were posters and complaints leaflets in reception. There was also a poster explaining that the practice welcomed any feedback in order to improve the service provided. Patients we spoke with were aware of the complaints procedure. None we spoke with had ever needed to make a complaint about the practice.

We saw that the practice recorded and investigated all complaints. Patients received an explanation about what had happened and were told what the practice had learned and what would be done differently in future. The practice also held a meeting to review anonymised complaints. This involved members of the PPG and their comments and suggestions were acted on to improve the quality of care. Minutes of practice meetings showed the complaints were regularly discussed and any learning or improvement identified by the whole staff group.

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 a high standard of personalised care, treatment and advice in a friendly and supportive environment and to involve patients in all decisions about their treatment.

We spoke with 12 members of staff who all understood the vision and values and their own responsibilities. They told us that these were discussed at the annual staff away day and at team meetings. Staff told us they felt able to contribute to these discussions and that managers listened to them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. All policies we looked at were up-to-date and there was a system in place to ensure these were reviewed regularly. There were systems in place to monitor the quality of the service being provided. This included using the Quality and Outcomes Framework (QOF) to measure the practices' performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed its performance was generally above national standards. The data was discussed at practice meetings with a view to maintaining or improving outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice was part way through an audit related to stoke prevention in patients with atrial fibrillation (AF) but had already decided upon six action points to improve patient care. We saw that incidents, complaints and other feedback were regularly discussed at staff meetings and learning identified with actions taken to follow this up. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where some risks had been identified and action plans had been produced and implemented, for example risks related to work, such as lone working.

We looked at minutes from the regular staff meetings and found that performance, quality and risks had been discussed.

The patient services manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, induction policy, and management of sickness) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff. This included sections on equality, whistleblowing, and harassment and bullying at work. Staff we spoke with knew where to find these policies when needed.

Leadership, openness and transparency

Staff told us the GPs and managers were approachable and listened to all members of staff. All staff were involved in discussions about how to run the practice and how to develop and improve it. We saw from minutes that there were regular team meetings. Staff told us that they felt confident about raising any issues at team meetings. We also noted that team away days were held every year. Staff said they felt respected, valued and supported in their work.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG) (this is a group of patients who work with the practice to improve services and the quality of care), surveys and complaints received. It had an active PPG with 30 members which met every quarter. A further 900 patients formed a virtual PPG receiving minutes and contributing online. We spoke with 2 members of the PPG and they were very positive about the role they played and told us they felt the practice engaged well with the PPG.

The practice had also gathered feedback from staff at team meetings, away days and discussions. Staff told us they

Are services well-led?

Good

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

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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. There were regular meetings to discuss clinical matters. We looked at 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.

The practice was a GP training practice. GP registrars were supported with daily debriefs and regular tutorials.

The practice had completed reviews of significant events and other incidents and shared any learning with staff at meetings. For example, we saw evidence that following a review of a possible vaccination error, all staff were reminded of the need to correctly record both the name and the batch number of the vaccination.