Northcroft Surgery

Quality Report

Northcroft Surgery
Northcroft Lane
Newbury
Berkshire
RG14 1BU
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Northcroft Surgery, Northcroft Lane, Newbury Berkshire, RG14 1BU. This was the first inspection of the practice under the new CQC comprehensive inspection approach and was undertaken to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Overall the practice is rated as good and all domains and patient groups carrying the same rating.

Our key findings were as follows:

- The practice offered a range of appointments and patient feedback showed the practice to be responsive to meeting patient requests for appointments.
- The practice sought the views of patients and staff in planning future service development. For example patients were asked to comment on the practice move to new premises.
- The practice was clean and tidy and the risks of cross infection were reduced by operation of safe systems.
- Patients with complex care needs were involved in the preparation of their care plans.
- Longer appointments were available for patients who were vulnerable or had complex care needs.
- The practice achieved all the national targets for care and review of patients with specific long term medical conditions in 2014/15.

There were some areas of practice where the provider needs to make improvements.

The provider should:

- Share learning from significant events with secondary care providers when the incident involves care and treatment provided by more than one party.
- Take the opportunity to widen the scope of clinical audit and share outcomes from audit to further improve patient care and outcomes.

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 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 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 identified via appraisals had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. The most recent data showed that patients rated the practice higher than others for several aspects of care. This showed an improvement from earlier patient surveys. 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 extensively with the local Clinical Commissioning Group (CCG) and neighbouring CCG's 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 appropriate facilities and was well equipped to treat patients and

Summary of findings

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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and business plan and recognised the need and importance to develop improved premises. Staff were clear about the practice plans 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 management 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 upon. The patient reference group (PRG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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 urgent appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients in this group received a structured annual review to check that their health and medication needs were being met. The practice had achieved 100% of the national Quality and Outcomes targets for this group. For patients with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. 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 patients who were on the at risk register. Immunisation rates were high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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.

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People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability. It had carried out annual health checks for 95% of patients with a learning disability. It offered longer appointments for vulnerable patients and designated an appointment in every morning GP clinic specifically for vulnerable patients. One of the GPs took a lead role in ensuring care for vulnerable patients met their needs.

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

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The results from the national patient survey undertaken in 2014 and completed by 117 patients showed a varying level of satisfaction with the services provided by both GPs and nurses at the practice. The ratings relating top care and support from the GPs were not as positive as other practices within the local area. For example, 78% said the GP was good at listening to them compared to the CCG average of 88%. Seventy eight per cent said the GP gave them enough time compared to the CCG average of 86% and 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 93%. The results from the same survey showed that patients were very positive about access to appointments with the GPs and nurses. Eighty three per cent described their experience of making an appointment as good compared to the CCG average of 78%, 77% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and 81% said they could get through easily to the surgery by phone compared to the CCG average of 76%.

The practice survey conducted between July and September 2014 and completed by 146 patients showed a far more positive response. Eighty one per cent of patients said the GPs involved them in decisions about their care and the overall feedback on care and support received was very positive. The practice had received 56 returns to the friends and family test since January 2015 and of these 48 patients said they were extremely likely or likely to recommend the practice to others.

We received 32 completed CQC comment cards. These had been filled out by patients who attended the practice in the two weeks prior to our inspection. All of the comment cards contained positive comments about the care and treatment received from the GPs and nurses and about accessing appointments.

We spoke with nine patients on the day of the inspection. Again we received positive feedback from all the patients we spoke with.

Areas for improvement

Action the service SHOULD take to improve

- Share learning from significant events with secondary care providers when the incident involves care and treatment provided by more than one party.
- Take the opportunity to widen the scope of clinical audit and share outcomes from audit to further improve patient care and outcomes.

Northcroft 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 an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services. They are granted the same authority to enter registered persons' premises as the CQC inspectors. The team was accompanied by a CQC Inspection Manager in an observer role.

Background to Northcroft Surgery

The practice operates from a purpose built surgery which was first opened in 1983 and extended in 2002. The practice intends to move to new larger premises in the summer of 2016. Services are provided to a registered practice population of approximately 8,850 and this population is drawn from an area of low income deprivation. There is a slightly higher than average number of patients in the age range of 25 to 49.

There are six GPs working at the practice of which two are full time and four are part time. Four of the GPs are partners and two are salaried GPs. Four of the GPs are female and two are male. The practice has one nurse practitioner, a practice nurse and a health care assistant. At the time of our inspection there was a vacancy for a further part time practice nurse. The practice manager is supported by a team of administration and reception staff. The practice delivers services via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

The practice is open between 8am and 6:30pm Monday to Friday. Appointments are from 8:30am to 11am every morning and 4pm to 6:20pm daily. Extended hours surgeries are offered every Wednesday evening until 7:50pm and every other Saturday. In recent months the surgery had been opening every Saturday morning when longer appointments were available.

Services are provided from: Northcroft Surgery, Northcroft Lane, Newbury, Berkshire, RG14 1BU

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by Westcall. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the patient website.

Why we carried out this inspection

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

This provider had not been inspected before. 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

Prior to the inspection we contacted the Newbury and District Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Northcroft Surgery. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 9 June 2015. We spoke with nine patients, four GPs and six staff. We reviewed 32 CQC comment cards that had been completed in the two weeks prior to our inspection. As part of the inspection we met with the practice manager and looked at the management records, policies and procedures.

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)

The practice provided services to five local care homes and had a larger than average number of patients in the age range of 25 to 49.

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to promote and manage safe delivery of services and 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. For example the nurse practitioner reported when a vaccine fridge had been inadvertently switched off. The fridge recovery procedure had been followed and the plug sockets protected to avoid a similar occurrence in the future.

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 and so could show evidence of a safe track record.

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 17 significant events that had occurred during the last year and saw the practice had recorded, reviewed and taken action on significant events in line with their procedure.

Significant events were discussed as and when they arose by the GPs and other staff were involved when the incident related to their area of responsibility. We saw that incidents were reported by staff as well as GPs and heard from staff that they were encouraged to make such reports. For example, a nurse we spoke with told us about reporting an incident when they had administered a vaccination ahead of schedule. There was evidence that the practice had learned from these and that the findings were shared with relevant staff via their line managers or the practice manager.

Staff were aware of the incident forms used within the practice and where these were kept but told us they would advise the practice manager and collect a form to complete if they needed to report a relevant event. The incident records we saw were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example the learning had been shared regarding carrying out additional checks to ensure female patients who may be pregnant were not referred for x-rays.

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.

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 GPs, practice nurses and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice had undertaken an audit of safeguarding processes and procedures in response to an incident in the locality. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors, the local authority and school nurses.

There was a chaperone policy, which was visible on the waiting room noticeboard, in consulting and treatment rooms and on the practice website. (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. Both nurses and the health care assistant had completed 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 adults who may be vulnerable). The practice ensured a chaperone was present during the procedure to fit contraceptive coils.

Medicines management

We checked medicines that were held 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.

Processes were in place to check medicines were within their expiry date and suitable for use. We checked eight batches of medicines and all were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had a robust system in place for both blank prescription forms for use in printers and those for hand written prescriptions. They were handled in accordance with national guidance, tracked through the practice and kept securely at all times.

We saw that the practice had reviewed their performance in response to prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. This showed the practice performed well in prescribing of hypnotic medicines which require careful consideration before being prescribed because their prescribing rate was 0.2 compared to the national average of 0.32.

There was a system in place for the management of high risk medicines. This included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

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. We found all PGDs were current and none were due for updating until July 2015 at the earliest. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and were competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and they received support in their role from a named GP as well as updates in the specific clinical areas of expertise for which they prescribed.

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 manager and nursing staff we spoke with told us they liaised with the cleaning contractors promptly if they found appropriate standards were not being maintained.

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 for example, when assisting with minor operations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The procedure to follow in the event of a needle stick injury was displayed in all consulting and treatment rooms.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. They were also able to carry out staff training on infection control having worked with the clinical commissioning group (CCG) lead for infection control. Infection control audits had been carried out in the last two years in conjunction with CCG infection control lead. Any improvements identified for action were completed on time. For example all staff had their hand washing techniques checked and were advised where they could make improvements. A second check showed staff were following best practice and achieving

appropriate standards of hand hygiene. The consulting and treatment rooms had also been cleared of unnecessary equipment and furnishings to reduce the risk of cross infection.

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 both consulting and treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings) which followed the recommendations of the last risk assessment. Records confirmed the practice was carrying out 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 requiring a test was routinely tested and displayed stickers indicating the last testing date which was November 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example the ECG machine, ultrasound machine and the fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy that set out the standards 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 (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).

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. For example, when one of the medical secretaries was on holiday another member of staff increased their hours to maintain secretarial services. 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.

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, 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. Staff had access to panic buttons and keys on the computer in the event of an emergency.

The practice used a nationally recognised piece of computer software that identified any problems with following up medicine reviews and lab results and alerted GPs to take action to rectify the problem.

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. The notes of the practice's significant event reviews showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

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. 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

Good

Are services safe?

recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in 2014.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised 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 guidance from local commissioners was readily accessible via the practice computer system. The practice used a computer programme that highlighted best practice guidelines when a diagnosis was entered on a patient record. There was an automated system to update guidelines when new versions were released. New guidelines were discussed by partners at their weekly meetings. GPs and nurses we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

GPs and nurses 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. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they led 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. Both GPs and nurses we spoke with were open about asking for and providing colleagues with advice and support. For example the nurse prescriber told us they were able to access advice from GPs promptly if they had any questions about prescribing.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. 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 looked at a sample of three care plans and saw they were updated and agreed with the patient. GPs were given protected time to visit patients at home to develop and update care plans if the patient was unable to attend the practice. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

Information about patient's care and treatment, and their outcomes, was routinely collected and monitored and this information was 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 staff collected was collated to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last two years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Two of the completed audits were limited in scope because the GP who carried them out reviewed patients from their own registered patient list. However, there was evidence that changes had been made arising from the audits. One of the audits reviewed the treatment of patients with peripheral arterial disease (a disease where blood supply is restricted to the leg muscles). The first audit found four patients with this condition and one had not received the appropriate medicine for this condition. The GP took action to review prescribing for patients with this condition. The audit was repeated six months later when six patients were identified. All six were receiving the appropriate medicine and had completed relevant screening in accordance with best practice guidelines. We noted that the results from clinical audits were not always shared with the full team of GPs at the practice and the benefits arising from clinical audit were therefore limited.

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 audit was repeated annually and results showed that the minor procedures were carried out effectively and consent to the procedure had been obtained.

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

Good

Are services effective?

(for example, treatment is effective)

voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit of repeat prescribing which included 15 different medicines. We saw that when required the GPs recalled patients to review their repeat medicines and ensure the medicine remained appropriate and met prescribing best practice in line with national guidelines.

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 100% of the total QOF target in 2014/15. Specific examples to demonstrate this included:

- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related QOF indicators was better than the national average.
- The dementia diagnosis rate was above the national average

The practice's prescribing rates were also better than national averages and the practice had achieved 96% of the local CCG prescribing targets. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked 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. There was a system to check that medicine alerts were read and action taken.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was also a register of patients diagnosed with cancer and the multidisciplinary team also discussed the care and treatment needs of this group of patients.

The practice also kept registers of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including homeless and patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions such as Diabetes and COPD. We were shown data that confirmed the practice had achieved maximum QOF points for completing the reviews for this group of patients. We saw that the most current review process for patients with diabetes was being followed with the focus being placed on the patient agreeing their personal goals for improving their health and reducing the long term impact of their condition. One of the GPs and the lead nurse for diabetes had undertaken training called 'pitstop' in the last year which enhanced their skills in transferring patients who took insulin from oral to injectable administration.

Effective staffing

Practice staffing included GPs, practice nurses, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one having an additional diploma in sexual and reproductive medicine, and two with diplomas in obstetrics and gynaecology. 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 personal development plans were identified. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses, in managing information and in infection control.

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 administration of vaccines and prescribing. Those with extended roles including seeing patients with long-term conditions such as asthma, COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. All communications from hospitals, other health care providers and out of hours reports were seen and actioned by a GP 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. We noted that if correspondence was not completed on the day it was received the GP was reminded or the information reallocated to another GP for action.

Emergency hospital admission rates for the practice were low at 62.41 compared to the national average of 91.37. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. A member of staff had been appointed as care coordinator and they made contact with any patient from this group who had been admitted immediately after discharge. (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 taking action on hospital communications was working well in this respect.

The practice held multidisciplinary team meetings every month to discuss patients with complex needs. For example, patients from vulnerable groups, those with end of life care needs and children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice worked with the local consultant in diabetes by holding 'virtual' clinics via telephone conference to discuss the care of patients with diabetes, This supported the care and treatment of patients who required an enhanced level of input to the management of their condition.

Information sharing

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and this was in operation. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Staff used an electronic patient record to coordinate, document and manage patients' care. All staff received training on the system relevant to their roles and responsibilities. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. During our discussions with staff we were given examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All GPs and practice nurses demonstrated a clear understanding of the Gillick

Good

Are services effective?

(for example, treatment is effective)

competency test. (These are 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 policy for documenting consent for specific interventions. For example, for all minor surgical procedures patient consent was documented in the electronic patient notes. We saw the practice had completed an audit of minor surgery which confirmed consent had been received in all cases.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the local authority and the clinical commissioning group (CCG) to help focus health promotion activity. One of the GPs was the chair of the CCG and they ensured their colleagues were kept informed of local priorities.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 369 patients in this age group took up the offer of the health check in 2014 following a campaign to increase take up the number of health checks undertaken was the highest in the CCG.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 89% of patients over the age of 16 and referred to smoking cessation clinics. Ninety six per cent of patients with long term conditions had their smoking status recorded and we found that of those 96% had been offered smoking cessation advice. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice identifies patients with a learning disability and holds a register of this patient group. In 2014 41 out of 42 patients in this group received an annual health check. Ninety eight per cent of patients on the practice mental health register had received a physical health check in 2014.

The practice's most recent performance for the cervical screening programme was 80%, which met the national target and was similar to other practices in the CCG. This had improved since March 2014. Patients who failed to attend for their screening were followed up. The practice also encouraged its patients to attend national screening programmes for bowel cancer, breast cancer screening and chlamydia 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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 74.3%, and at risk groups 61.1%. These were above national averages.
- Childhood immunisation rates for the vaccinations given to under twos' was on average 95% with a similar level of coverage for five year olds. This exceeded the national target of 90%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the data available from the national patient survey conducted between January and March and July and September 2014.

The results showed mixed levels of satisfaction from the 117 patients who completed the questions about how they were treated.

- 78% said the GP was good at listening to them compared to the CCG average of 88% and national average of 87%.
- 78% said the GP gave them enough time compared to the CCG average of 86% and national average of 85%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 92%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. 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 and said their dignity and privacy was respected.

We observed all consultations and treatments were carried out in the privacy of a consulting or treatment room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Calls from patients were taken by staff who were shielded from the waiting room by glass partitions which helped keep patient information private. In response to patient and staff suggestions patients who wished to speak with reception staff in private could do so in an area away from the reception desk. Additionally, 90% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

There was a system in place for patients in a wheelchair to alert reception staff to their presence at the practice entrance and staff were then able to assist the patient to access the practice.

Care planning and involvement in decisions about care and treatment

The 2014 national survey results for the practice showed the 117 patients who responded were not wholly positive when answering questions about their involvement in planning and making decisions about their care and treatment. For example:

- 75% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 82%.
- 65% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 75%.

These responses were not reflected in the survey of 146 patients carried out by the practice which showed 81% said they were satisfied with their involvement in decisions about their care and treatment.

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.

Patient/carer support to cope emotionally with care and treatment

The 2014 national patient survey results, from 117 patients, showed mixed opinion about the emotional support provided by the practice and rated it well in this area. For example:

- 74% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 83%.

Good

Are services caring?

- 79% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 77% and national average of 78%.

However, the views of the patients we spoke with during our inspection, the comment cards we reviewed and the practice survey of 146 patients did not align with this survey information. For example, these highlighted that staff responded with care and compassion when they needed help and provided support when required.

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

GPs contacted families who had suffered bereavement. The contact included an offer of a consultation at a flexible time and access to advice on how to find a support service.

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, the practice had used additional funds to provide extra Saturday morning clinics during the winter of 2014/15.

We saw that the practice engaged with both the NHS England Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw plans for the new surgery premises which would be shared with a neighbouring practice and provide facilities for visiting health and social care staff to offer a wider range of services.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from local patient surveys and the virtual patient reference group (PRG) (A PRG is a group of patients who have agreed to contribute their views about the way the practice delivers services. They are contacted by phone or electronic communication). For example, the practice made all appointments available to book on line in response to the last survey.

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. The practice completed an annual health check for 97% of these patients and made a telephone call the evening before their health check to remind them to attend. The practice also registered patients who were homeless and ensured these patients received communication about their health needs by receiving results and correspondence about their care and treatment at the practice address. The majority of the practice population were English speaking patients but access to face to face and telephone translation services were available if they were needed. There was a clear policy that promoted advocacy services for patients who may require an advocate to support them. There was a system for flagging vulnerability in individual patient records and we saw three examples of this system being used.

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. The consulting rooms were also accessible for patients with mobility difficulties and there toilets with wide door access and baby changing facilities. There was a waiting area with sufficient space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. An induction loop system was available to assist patients who used hearing aids.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. The practice provided equality and diversity training through e-learning. The training record we reviewed showed us that all staff had completed the equality and diversity training in the last 12 months.

Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday with late opening every Wednesday until 20:00. Appointments were available from 08:30 to 11:00 each morning and 16:00 to 18:00 every afternoon. In addition the practice provided appointments between 18:30 and 20:00 each Wednesday and Saturday clinics every other Saturday morning. There were a mix of appointments available every day including: book in advance, book on the day, urgent and telephone consultations. One appointment was reserved every morning with each GP for the use of vulnerable patients. Practice nurse clinics ran throughout the day.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to five local care homes as and when a patient required.

The 2014 national patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 83% described their experience of making an appointment as good compared to the CCG average of 78% and national average of 73%.
- 77% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.
- 81% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 72%.

Comment cards we reviewed and the views of patients we spoke with reflected a similar level of satisfaction with access to appointments.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance.

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. The complaints procedure was displayed in the waiting room, contained in the patient information leaflet and on the patient website. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 15 complaints received in the last 12 months and found all had been investigated and dealt with in a timely way. Patients had received a full response to the concerns and when an apology was due this was forthcoming. Recording of complaints was comprehensive with actions identified and learning points disseminated.

The practice reviewed complaints annually to detect themes or trends. The last review had not identified any themes in complaints received and the number of complaints had reduced in the last year. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, an area of the practice was identified to enable patients to hold private conversations with reception staff.

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 mission statement to offer good medicine in a small and friendly environment. It also had a vision which embraced the use of modern medical technology and had a stated aim to become a training practice in the future. The practice had a five year business plan covering 2014 to 2019. This recognised the opportunities the new practice premises would afford in further developing services for patients. It included offering clinics by secondary care consultants and bringing in voluntary agencies.

We spoke with six members of staff and they all knew and understood the values and long term goals of the practice. They were clear about what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a folder, which staff we spoke with were familiar with, on the desktop on any computer within the practice. We looked at five of these policies and procedures and all five we looked at had been reviewed at least every two years and were up to date. The practice had a robust system in place to alert staff to any changes in governance policies and staff were required to confirm they had received and read the updates.

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 lead GPs identified for safeguarding of both children and adults. We spoke with six members of staff. 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.

GPs in the practice rotated through the role of management lead. The lead GP and practice manager took an active role for overseeing that the systems in place to monitor the quality of the service were implemented consistently and were appropriate to the needs of patients. The included using the Quality and Outcomes Framework to measure its 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 that it had achieved 100% of the targets during 2014/15. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example annual audit of the quality and outcomes achieved from minor surgery. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. 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 carried out risk assessments and where risks were identified action plans had been produced and implemented, for example the risk assessment for ensuring vaccines were safe to use had been updated following an incident when a vaccine fridge had been accidentally switched off.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction policy and maternity leave which were in place to support staff. We were shown the staff handbook that was available to all staff. It included sections on equal opportunities and bullying and harassment at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook. Staff we spoke with were aware of the whistleblowing policy and told us they would not hesitate to report any instances of poor or unacceptable behaviour by colleagues if they witnessed it.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and took the time to listen to all members of staff. Staff were involved in discussions about how to run the practice and how to develop the practice. Staff we spoke with told us they attended team meetings and we saw that these took place at regular intervals. For example, the GPs met every week, the administration and reception staff every four to six weeks and the nursing team every six to eight weeks. All meetings were formally recorded and staff told us they contributed to the agenda's.

Are services well-led?

Good

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

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted the practice held an annual whole practice meeting. Ideas and concerns staff had were relayed to partners via the regular team meetings. Staff said they felt respected valued and supported and we were given examples of staff involvement in planning the move to new practice premises due to take place in 2016.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through surveys agreed with the patient representative group (PRG) and complaints received. It had an active PRG which included representatives from various population groups. The PRG had produced a report in response to the last patient survey which set out actions arising from the patient responses. We saw that more appointments had been made available to book online as a result.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. For example, the last practice survey included a question on patient involvement in decisions about their care because the national survey scores for this question were not as good as other practices in the area. The opportunity to seek more views on this question showed a significant improvement of 16%. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. This was evident in patients being asked to comment upon the new practices premises project. The plans for the new practice were displayed in the entrance to the waiting room.

The practice had also gathered feedback from staff through day to day discussions and staff meetings. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their professional development through training and GP support. They told us they all received annual appraisals and there was an appraisal file which contained the records of appraisal discussions. Staff told us that the practice was very supportive of training and we saw that an online training account was available for all staff. There was an expectation that staff would complete a series of training modules that were relevant to their roles and responsibilities. GPs and practice nurses took part in education sessions which involved guest speakers and trainers.

The practice had completed reviews of significant events and other incidents and these were shared with staff at meetings or by the practice manager.