The Croft 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Croft Practice on 17 July 2015. Overall the practice is rated as good.

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

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.
- 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.
- The GPs were proactive in identifying and undertaking regular audits of clinical care to improve treatment and ensure best practice was being implemented.
- There was a strong culture of multi-disciplinary working. All of the GPs were actively engaged in meetings with representatives from health and social care in order to avoid hospital admissions for patients with complex health and social care needs.
- The practice had expertise in providing high quality end of life care and bereavement support.
- Patients said they could always get to see a GP on the same day if they needed to but that it was sometimes difficult to get through on the telephone, particularly in the mornings.
- Staff felt supported by management.
- The practice premises were clean and hygienic.

We saw one area of outstanding practice:

Summary of findings

- All of the GPs were actively engaged in multi-disciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term health conditions and complex social needs. All of the GPs attended fortnightly meetings with the "pro-active care" (PAC) team which included community nurses, social workers, and a community pharmacist where decisions about care planning were made and documented in a shared care record. The practice provided us with evidence that demonstrated the number of patients under the care of the PAC team had increased by 65% since 2013. It was also able to demonstrate a reduction in hospital admissions.

The areas where the provider should make improvement are:-

- Ensure that a written policy and procedure is in place for reporting significant events which includes the definition of a significant event and the procedure for recording and reporting.
- Ensure significant events and safety alerts are recorded in a consistent format in order to demonstrate what lessons have been learned, how these have been shared with staff and what action has been taken as a result.
- Organise regular clinical meetings for medical and nursing staff to facilitate knowledge sharing and learning from significant events on a more structured basis.
- Continue to implement and review measures to improve telephone access for appointment booking.
- Ensure that measures being implemented to improve patient participation are fully embedded.

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 mental 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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients told us they were able to get an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. However, patients also told us it was sometimes difficult to get through to the practice on the telephone, particularly in the mornings. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to

Summary of findings

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 leadership structure in place and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. We saw evidence that the practice was in the process of setting up a patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The GPs worked closely with local residential and care homes and undertook regular visits in response to patient needs. The practice was actively engaged in multi-disciplinary meetings to discuss patients identified as at risk of hospital admission to ensure that they were supported to remain at home if that was their choice.

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. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The GPs had close links with the health visiting service and met weekly with the senior health visitor. The GPs also worked closely with the local child and adolescent mental health services and provide shared care to patients receiving this service.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the

Summary of findings

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. Extended opening hours were in operation on Saturday mornings for pre-booked appointments. The practice offered an on-line appointment booking and repeat prescription ordering service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. It had carried out annual health checks for people with a learning disability. 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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice could refer patients to a primary care mental health practitioner who ran clinics from the practice premises. The GPs also had rapid access to secondary mental health services. The practice had close links with the local mental health service provider who provided regular training to GPs on mental health issues in conjunction with the local Clinical Commissioning Group (CCG).

Summary of findings

What people who use the service say

We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service. We also spoke to four patients on the day of the inspection. The feedback we received was mainly positive. Patients told us that they received an excellent service. They told us that the doctors and nurses listened to them and spent time explaining things to them. They said they thought the practice was always clean and tidy. Six patients who fed back using the comments cards told us that that reception staff could be abrupt and unhelpful. Three patients said it was difficult to get through on the telephone in the mornings.

We reviewed the most recent data available for the practice on patient satisfaction. Results of the 2015 national GP survey showed that patients rated the practice higher than average nationally and the local Clinical Commissioning Group (CCG) area for several aspects of care. For example, 96% of practice respondents said the last GP they saw was good at listening to them. 86% of respondents said they would recommend the surgery and 89% said the last GP they saw or spoke with was good at involving them with in their care. There were also areas highlighted in the national survey that the practice could improve. For example, only 42% of respondents found it easy to get through on the phone. 73% of respondents found the receptionist at the practice helpful. Results in these two areas were below both the local CCG and the national average.

The practice had undertaken its own survey of patient views in February 2015. 130 patients responded and the results showed a high level of satisfaction with the care and treatment provided by the practice. For example 87.5% of patients described their experience of using the practice excellent or good. 97% of respondents said they were treated with care and concern. However, in line with feedback from the national survey and patient comments cards 37% of respondents said it was not very easy to get through on the phone. Some patients had also commented about the unhelpfulness of reception staff.

We saw evidence that the practice manager had analysed the results of the patient survey and reviewed these with the whole practice team. We saw that areas for action had been identified and implemented, for example the introduction of on line booking and additional training for receptionists. It was clear from our discussions with the GPs and the practice manager that the practice was fully aware of the feedback from patients and had responded to their concerns.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:-

- Ensure that a written policy and procedure is in place for reporting significant events which includes the definition of a significant event and the procedure for recording and reporting. Ensure significant events and safety alerts are recorded in a consistent format in order to demonstrate what lessons have been learned, how these have been shared with staff and what action has been taken as a result. Organise regular clinical meetings for medical and nursing staff to facilitate knowledge sharing and learning from significant events on a more structured basis.
- Continue to implement and review measures to improve telephone access for appointment booking.
- Ensure that measures being implemented to improve patient participation are fully embedded.

Outstanding practice

- All of the GPs were actively engaged in multi-disciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term health conditions and complex social needs.

Summary of findings

All of the GPs attended fortnightly meetings with the “pro-active care” (PAC) team which included community nurses, social workers, and a community pharmacist where decisions about care planning were made and documented in a shared care record. The practice provided us with evidence that demonstrated the number of patients under the care of the PAC team had increased by 65% since 2013. It was also able to demonstrate a reduction in hospital admissions.

The Croft Practice

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 CQC pharmacy inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to The Croft Practice

The practice provides general medical services to approximately 11,000 patients from its main surgery in Eastergate, together with branch surgeries in Yapton and Walberton. We only visited The Croft surgery in Eastergate for this inspection. There are seven GPs, four male and three female. The practice also employs four practice nurses and two health care assistants. The practice provides a wide range of services to patients, including minor surgery and cryotherapy, ante-natal care, childhood immunisations, cervical screening and smoking cessation.

The practice provides a service to all of its patients at three locations :-

The Croft Surgery - Opening hours 08:30 until 18:00 Monday to Friday. Extended opening Saturday mornings from 08:30 until 12:00

Barnham Road, Eastergate, Chichester, West Sussex PO20 3RP

Meadowcroft Surgery- Opening hours 08:30 until 17:00 Monday, Tuesday, Thursday, Friday and 08:30 until 14:00 on Wednesdays.

Bilsham Road, Yapton, Arundel, West Sussex BN18 0JG

Flintcroft Surgery Opening hours from 08:45 for pre-booked appointments

The Street, Walberton, Arundel, West Sussex BN18 0PJ

Our inspection was undertaken at The Croft surgery only.

The practice population is spread over a largely rural area and serves all age groups, the proportion of which are in line with national average. It does however have a higher than average proportion of its population over the age of 65 years.

The practice has opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services or NHS 111.

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Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the Coastal West Sussex Clinical Commissioning Group (CCG) and NHS England to share what they knew.

Detailed findings

During our visit we spoke with a range of staff including, the GPs, the practice manager, the practice nurses, administrative staff and receptionists. We also spoke with other health and social care professionals who worked in the local community. We examined practice management policies and procedures. We spoke with four patients. We also reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety 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. Although the practice did not have a written policy and procedure in place for reporting significant events, the staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents.

We reviewed the practices significant events log and minutes of meetings where these were discussed for the last year. This showed the practice had managed these over time 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 which involved staff reporting all incidents to the practice manager who recorded the details on a significant event log.

We reviewed records of significant events that had occurred during the last year. We saw that the practice's significant event log described the details of the event, the date and the actions required. However, it was noted that these records were a narrative and did not consistently or clearly detail the information of the event. For example, exact dates, who reported it, the learning outcomes, with who and how the details and learning outcomes were shared, and review dates for following up actions. We saw from meeting notes that significant events were discussed at monthly practice meetings.

The practice had a system for ensuring all external safety alerts were responded to appropriately. All incoming alerts were reviewed by the practice manager who ensured that information was disseminated to relevant staff and that appropriate action was taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record 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 and training 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 chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. This ensured that patients could have someone else present for any consultation, examination or procedure if they wished. This could be a family member or friend or a formal chaperone from the practice's nursing team.

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 were arrangements in place 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 room temperature and 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. All the medicines we checked 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. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Good

Are services safe?

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 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 saw sets of up to date PGDs.

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.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use there was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that the lead had carried out audits in the last year and that any improvements identified for action had been addressed.

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

The practice had arrangements in place for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices 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).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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.

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

Good

Are services safe?

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included 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.

The practice had carried out a fire risk assessment in 2015 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 guidance from local commissioners was readily accessible to all the GPs. The GPs told us that they met every morning before they started their surgeries to help facilitate clinical knowledge sharing and discuss new best practice guidelines. The practice nurses could also attend this meeting.

The GPs 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 co-ordinated 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 lead in specialist clinical areas such as chronic disease management, mental health, contraception and palliative care. 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. However, it was noted that some clinical staff we spoke with said they would value more structured, regular clinical meetings to facilitate this on a more formal basis.

The practice used 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.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input and scheduling clinical reviews.

The practice showed us six clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, in response to the Committee of Safety of Medicines (CSM) advice that all patients taking a medicine particular medicine used to treat predominantly rheumatological illnesses should have their blood monitored at least every two months. The practice undertook a search on its clinical system to highlight all patients taking this medicine. All patients were reviewed to check that they were being followed up by specialist teams. We noted a positive culture in the practice around audit and quality improvement.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed well in most areas, for example 92.8 % of patients aged 75 or over with a fragility fracture on or after 1 April 2012, were currently being treated with an appropriate bone-sparing agent.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw evidence that the practice was taking action to ensure these were being addressed.

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. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

Good

Are services effective?

(for example, treatment is effective)

The practice also kept a register of patients identified as being at high risk of admission to hospital. Structured annual reviews were also undertaken for people with long term conditions for example those with diabetes and people with learning disabilities.

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 surgeries in the area. We saw evidence that the practice used this information to review clinical practice.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. 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 their learning needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

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, cervical screening. Those with extended roles were also able to demonstrate that they had appropriate training to fulfil these roles. For example, on the management of diabetes.

Working with colleagues and other services

All of the GPs were actively engaged in multi-disciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term health conditions and complex social needs. All of the GPs attended fortnightly meetings with the "pro-active care" (PAC) team which included community nurses, social workers, and a community pharmacist where decisions about care planning were made and documented in a shared care record. We spoke with members of the multi-disciplinary team who all felt this system worked well. They all commented on how positively engaged with the process all the GPs from this practice were. Care plans were in place for patients with complex needs and were shared with other health and social care workers including out of hours services as appropriate. The practice provided us with evidence that demonstrated the number of patients under the care of the PAC team had increased by 65% since 2013. It was also able to demonstrate a reduction in hospital admissions. For example, for one patient who had seven hospital admissions in 2013, the number of hospital admissions since being a patient with the PAC team had reduced to 1 in 2014.

The GPs also worked closely with the health visiting service and met weekly with a senior health visitor where they shared concerns and ideas about families they were jointly working with. The health visitor told us that they found this a useful forum for discussing about aspects of child and family health and current prescribing practice for common conditions. There were also close links with staff from the local mental health services. A primary care mental health practitioner service provided a service to patients based in the practice premises.

Information sharing

Roles and responsibilities for dealing with information about patients from other providers were clearly defined within the practice. The practice used several systems to communicate with other providers. For example, electronic results for pathology and Out of Hours communications were emailed directly to the GPs. Radiology results were also sent via email to a generic email and printed off for GPs to view and then scanned in to the patients' electronic notes, Hospital discharge letters were sent to the practice via post and were also scanned in to the patients electronic notes. 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. 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 clinical staff had received training on and understood the Mental Capacity Act 2005. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Good

Are services effective?

(for example, treatment is effective)

The practice had procedures for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over. The practice provided a smoking cessation clinic. There was a range of patient literature on health promotion and prevention available for patients in the waiting area. The practice website provided patients with health advice and information about healthy lifestyles and common illnesses.

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 in 2015, a survey of 130 patients undertaken by the practice.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 86% of respondents would recommend this practice to someone new to the area compared to the national average of 78% and the local clinical commissioning group (CCG) average. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 96% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 91% said the GP gave them enough time compared to the CCG average of 87% 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 completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Six comments were less positive and were in relation to the unhelpful attitude of some reception staff. This was in line with the national survey results where 73% of respondents found the receptionists at this practice helpful; this was below the national and local average. We also spoke with four 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.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice telephones were located away from the reception desk to help keep patient information private. There was a sign at the reception desk encouraging patients to maintain their distance at the reception desk in order to prevent them overhearing potentially private conversations between patients and reception staff.

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 above average in these areas. For example:

- 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 89% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it above average 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 81% and national average of 81%.
- 88% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.

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

Notices in the patient waiting room, on 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 were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We noted a strong ethos in the practice for providing compassionate care and support for people who had been recently bereaved. Two of the GPs provided support to terminally ill patients in the local children's hospice one of whom also had training and expertise in adult hospice care. The GPs told us they always contacted patients who had recently been bereaved and offered them a consultation at a flexible time and location to meet their family's needs and by giving them advice on how to find a support service. The patients we spoke with spoke highly of the compassion and care provided by the GPs and nurses at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were clearly understood.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, the practice had identified that it had a much a higher than average number of patients in nursing homes. We saw evidence that the practice was working within its locality to develop a new Nursing Home service. This included having a dedicated team managing these patents, including GPs, specialist nurses and a consultant geriatrician.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient survey. For example, in response to negative feedback about the helpfulness of reception staff, further training had been arranged to enable them to be more responsive to dealing with patients' needs. The practice had organised customer care training for its entire reception staff in September 2015.

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 majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

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 were access enabled toilets and baby changing facilities.

There was a large waiting area which had sufficient space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The surgery was open for appointments from 08:30 to 18:00 Monday to Friday and its telephone lines were staffed from 08:00 until 18:00 Monday to Friday. The practice also had extended opening hours on a Saturday morning from 08:30 until noon for pre-booked appointments.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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 on a daily basis to local care and nursing homes by a named GP to those patients who needed one.

The patient survey information we reviewed showed patients had mixed views to about access to appointments. For example:

- 61% described their experience of making an appointment as good compared to the CCG average of 73% and national average of 73%.
- 43% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.
- 42% said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 73%.

Patients we spoke with were satisfied with the appointments system; however they did comment that it could be difficult to get through on the telephone. They also commented that's whilst they often had to wait more

Good

Are services responsive to people's needs?

(for example, to feedback?)

than 15 minutes for their appointment they valued the fact that the GPs spent more than their allocated time with patients and placed more importance on this than having to wait. 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 four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice.

We spoke with the GPs and the practice manager about the issues concerning the appointments system. They told us that in response to the problems highlighted they had introduced on line booking in March 2015. They also told us that the practice was in process of investing in additional telephone lines and call queuing system and that this would be operational by the end of the year. We saw evidence of meetings that were taking place with the communications company that was installing the new system. The GPs also told us that they were able to maintain a responsive system to urgent care needs. A duty doctor provided an urgent care clinic in the morning and afternoon. Any patient who considered their need as being urgent could be accommodated on that day through these clinics. The patients we spoke with confirmed this to be the case.

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 on the website and on patient notice boards. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way, with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and saw that the practice had identified a common theme in relation to difficulties in making appointments. We saw evidence that the practice had plans in place to address this and improve the telephone system. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality patient centred care that was safe and effective. We found details of the vision which were set out in a document developed by the lead partner called "The Croft Practice – The Way Forward".

The staff we spoke with all knew and understood the vision. We looked at minutes of the practice meetings and saw that staff had been involved in discussions about the practice's vision.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in the practice manager's office. We saw that the practice was in the process of installing a system which would enable staff to access all the policies via the desktop on their computers. We looked at five of these policies and procedures and they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GP leads for safeguarding. The staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. They 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 it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action was taken to maintain or improve 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. Evidence from other data, from 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 regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example regular health and safety checks of the buildings and the environment.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance and quality, for example significant events and complaints had been discussed.

The practice manager was responsible for human resource policies and procedures. We saw a number of policies, for example disciplinary procedures and the management of sickness which were in place to support staff. We were shown the staff handbook that was available to all staff which included key human resource policies. The practice had a whistleblowing policy which had been issued to each individual staff member.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff.

We saw from minutes that team meetings were held every month. 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 were confident in doing so and felt supported if they did. Although the GPs and practice nurses met informally every morning before seeing patients, the nursing staff we spoke said they would value the opportunity to have more regular structured meetings to discuss clinical issues. Staff said they felt respected, valued and supported, particularly by the partners in the practice. However, it was noted that some of the practice nursing staff felt their skills could be utilised more in order to reduce demand on GP workload.

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

Are services well-led?

Good

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

regular surveys and complaints received. The practice was in the process of setting up patient participation group (PPG) which was due to have its first meeting in August 2015. We met with four patients who had agreed to become members of the group. They were very positive about their future role and told us they felt engaged with the practice. The practice carried out annual patient surveys. The practice manager showed us the analysis of the last patient survey. The results and actions agreed from these surveys were publicised in the practice newsletter. The practice manager told us that they would also be uploaded on to the practice website. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

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. There was evidence that the practice had taken action to address any areas identified for improvement. For example, the implementation of on line booking and customer care training for reception staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at staff files and saw that regular appraisals took place which included the identification of learning and training needs. Staff told us that the practice was very supportive of training and that they had regular protected time for in-house training sessions, supported by the CCG, where guest speakers and trainers attended.

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