Infirmary Drive Medical Group

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Infirmary Drive Medical Group on 4 February 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice regularly reviewed demand for appointments. Urgent appointments were available the same day
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

However, there were some areas where the provider needs to make improvements. The provider should:

- Review and strengthen the process currently in place for checking the expiry dates of medicines held in GP bags
- Review and strengthen the stock control process in the dispensary
- Review and strengthen the arrangements currently in place for dealing with patient safety alerts

Summary of findings

- Formalise the arrangements currently in place for carrying out infection control audits and continue with plans to ensure all staff receive infection control training as soon as possible

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.

Nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. Risks to patients were assessed and well managed.

Lessons were shared to make sure action was taken to improve safety in the practice.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology.

Although there was evidence of some effective medicines management we were not assured that the arrangements for checking out of date medicines held in GP bags were sufficient or that there was an effective stock control system in place in the dispensary. However, we felt that the issue with the GPs bags was an isolated incident and staff were able to tell us about the electronic stock control system they planned to implement in the dispensary. The practice did not have an effective system in place to ensure that patient safety alerts were acted upon.

The practice was clean and hygienic and good cleaning arrangements were in place. However, the arrangements for carrying out infection control audits were very informal and not all practice staff had received infection control training.

Effective staff recruitment practices were followed and there were enough staff to keep patients safe. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patients' needs were assessed and care was planned and delivered in line with current legislation. Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment and had received training appropriate to their roles.

Summary of findings

Data from the Quality and Outcomes Framework showed patient outcomes were comparable to local clinical commissioning group (CCG) and national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring effectiveness and had achieved 98.9% of the point's available (local CCG average 97.6% and national average 94.7%).

Achievement rates for cervical screening, flu vaccination and the majority of childhood vaccinations were either comparable with or above local and national averages.

There was evidence of clinical audit activity and improvements made as a result of this. Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Staff had received annual appraisals and were given the opportunity to undertake both mandatory and non-mandatory training.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients we spoke with during the inspection and those that completed Care Quality Commission comments cards said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. Information for patients about the service was available. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Results from the National GP Patient Survey published in January 2016 were comparable with or above CCG and national averages in respect of providing caring services. For example, 89% of patients who responded to the survey said the last GP they saw or spoke to was good at listening to them (CCG average 91% and national average 89%) and 90% said the last nurse they saw or spoke to was good at listening to them (CCG average 94% and national average was 91%).

Results also indicated that 94% of respondents felt the GP treated them with care and concern (CCG average 89% and national average of 85%). 92% of patients felt the nurse treated them with care and concern (CCG average 93% and national average 91%).

Information for patients about the services available was easy to understand and accessible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

The practice's scores in relation to access in the National GP Patient Survey were higher than local and national averages. The most recent results (January 2016) showed that 81% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 74% and the national average of 65%. 90% of patients reported that they were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.

The practice was able to demonstrate that it continually monitored the needs of their patients and responded appropriately. For example, as the practice had a higher than average percentage of elderly patients (11% of the patient population) they had ensured that they had an effective process in place to monitor and review patients at high risk of admission to hospital. The practice also offered a dispensing service for patients living in more remote locations.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. Staff understood their responsibilities in relation to the practice aims and objectives. There was a well-defined leadership structure in place with designated staff in lead roles. Staff said they felt supported by management. Team working within the practice between clinical and non-clinical staff was good.

The practice had identified areas in which they wanted to improve and could demonstrate that they had considered ways to do this. For example, the practice had carried out a capacity and demand survey to look at appointment and GP availability and were considering new ways of working as a result of this.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. There was an active Patient Participation Group (PPG) which met on a regular basis and worked with the management team to monitor services and implement improvements.

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 the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure (local clinical commissioning group (CCG) average of 98.9% and the England average of 97.9%) and with osteoporosis (CCG average 93.4% and England average 81.4%).

The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and the practice was proactive in ensuring that patients over the age of 75 were offered an annual health check. Monthly multidisciplinary meetings were held to review the care and support provided to patients at high risk of admission to hospital and comprehensive care plans were developed. A lead GP for patients at high risk of admission to hospital had been identified whose role include attending monthly multidisciplinary meetings at a local care home

The practice maintained a palliative care register and held flu and shingles vaccination sessions.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Longer appointments and home visits were available when needed. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Practice nurses were supported in undertaking additional training to help them understand and care for patients with certain long term conditions, such as diabetes.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) showed the practice had achieved good outcomes in relation to some of the conditions commonly associated with this population group. For example, the practice had obtained 100% of

Summary of findings

the points available to them for providing recommended care and treatment for patients with asthma (local CCG average of 99.3% and national average of 97.4%) and chronic obstructive pulmonary disease (CCG average 98.3% and national average 96%).

Diabetic patients were offered structured training on how to effectively self-manage their condition.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. There were processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary 'supporting families' meetings involving child care professionals such as health visitors.

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for 12 month and 24 month old babies and five year old children were comparable with local and national averages. For example, childhood immunisation rates for the vaccinations given to two year olds ranged from 93.9% to 98.8% (compared with the CCG range of 95.3% to 98.1%). For five year olds this ranged from 91.4% to 98.9% (compared to CCG range of 94.9% to 100%).

The practice's uptake for the cervical screening programme was 78.4%, which was comparable to the CCG average of 79.1% and national average of 74.3%.

Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice also provided contraceptive advice and a intra uterine device fitting 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 working age population, those recently retired and students had been met. The practice was open from 8am to 6pm on

Summary of findings

a Monday to Friday with appointments being available from 8.10am to 10.30am and 3pm to 5.20pm. The practice was also open after 6pm on Tuesday and alternate Wednesday evenings for pre bookable appointments.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. There was a designated nursing lead for patients with learning disabilities and these patients were invited to attend the practice for annual health checks and relevant vaccinations. Longer appointments for people with a learning disability were routinely available.

The practice had effective working relationships with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The practice was in the process of strengthening the arrangements in place to support patients who were carers and aimed to proactively rather than opportunistically identify carers. When carers were identified they were signposted to the local carers association for advice and support.

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).

At 96% the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face meeting in the last 12 months was higher than the national average of 84%. However, only 65% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented within the previous 12 months (national average 88%). The practice felt that this had been due to a gap in having an identified GP lead for mental health conditions. This gap had now been filled and the practice were committed to improvement in this area.

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The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Patients experiencing poor mental health were sign posted to various support groups and third sector organisations. Mental health counsellors, community psychiatric nurses, psychologists and alcohol support workers were able to use practice consultation rooms. The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests. Patients with complex mental health needs were allocated a named GP who worked with the patient to agree prescribing protocols and emergency attendance usage.

Summary of findings

What people who use the service say

The results of the National GP Patient Survey published in January 2016 showed the practice was performing above local and national averages. 272 survey forms were distributed and 117 were returned, a response rate of 43%. This represented approximately 1.5% of the practice's patient list.

- 91% found it easy to get through to this surgery by phone compared to a CCG average of 78% and a national average of 73%.
- 90% were able to get an appointment to see or speak to someone the last time they tried (CCG average 86%, national average 85%).
- 92% described the overall experience of their GP surgery as fairly good or very good (CCG average 88%, national average 85%).
- 91% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 81%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received six comment cards which were mostly positive about the standard of care received. Words used to describe the practice and its staff included first class, fantastic and the best. One of the cards contained a negative comment in relation to staff attitude.

We spoke with four patients during the inspection, two of whom were members of the practice patient participation group. All four patients said they were happy with the care they received; thought staff were approachable, committed and caring and could usually get a routine appointment within an acceptable period of time.

In advance of the inspection we also spoke with attached staff that worked closely with, but were not employed by the practice. This included a community midwife and a health visitor. They both reported that they had no concerns in respect of the practice, that there was effective communication and the practice GPs were responsive to their requests for information and advice

Areas for improvement

Action the service SHOULD take to improve

- Review and strengthen the process currently in place for checking the expiry dates of medicines held in GP bags
- Review and strengthen the stock control process in the dispensary
- Review and strengthen the arrangements currently in place for dealing with patient safety alerts
- Formalise the arrangements currently in place for carrying out infection control audits and continue with plans to ensure all staff receive infection control training as soon as possible

Infirmary Drive Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.** The team included a GP specialist advisor and a specialist advisor with experience of practice management.

Background to Infirmary Drive Medical Group

The practice is located in a semi-rural area in the market town of Alnwick, approximately 35 miles north of Newcastle-Upon-Tyne. The practice provides care and treatment to 9,577 patients from Alnwick and the surrounding areas. It is part of the NHS Northumberland Clinical Commissioning Group (CCG) and operates on a Personal Medical Services (PMS) contract. The practice is a part-dispensing practice and dispenses to patients from the Alnham, Edlingham, Hedgley, Ingram and Whittingham areas.

The practice provides services from the following address, which we visited during this inspection:

Infirmary Drive Medical Group, The Consulting Rooms, Alnwick, Northumberland, NE66 2NR

The practice is located in a modern purpose-built single storey building on the same site as Alnwick Infirmary. The practice shares the building with district nursing staff, health visitors, speech and language therapists and a podiatrist. All reception and consultation rooms are fully accessible for patients with mobility issues. On-site parking is available, which includes dedicated disabled parking bays. The hospital pay and display car park is located adjacent to the practice.

The practice is open from 8am to 6pm on a Monday to Friday with appointments being available from 8.10am to 10.30am and 3pm to 5.20pm. The practice is also open after 6pm on Tuesday and alternate Wednesday evenings for pre bookable appointments only.

The service for patients requiring urgent medical attention out-of-hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited (NDUC).

Infirmary Drive Medical Group offers a range of services and clinic appointments including chronic disease management clinics, cervical screening, family planning, childhood development and immunisations, cervical screening, travel advice, smoking cessation and minor surgery. The practice consists of:

- Four GP partners (two male and two female)
- Three salaried GPs (one male and two female)
- Five practice nurses
- Two health care assistants
- 28 non-clinical members of staff including an operational manager, IT manager, reception manager, dispenser, administration/reception staff, secretaries and cleaners.

The area in which the practice is located is in the eighth (out of ten) most deprived decile. In general people living in more deprived areas tend to have greater need for health services.

The practice's age distribution profile shows fewer patients than the national average under the age of 44 and more

patients than the national average over the age of 45. Average life expectancy for the male practice population is 78 (national average 79) and for the female population 82 (national average 83).

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 February 2016. During our visit we spoke with a mix of clinical and non-clinical staff including GPs, practice nurses, the operational manager, a dispenser and administration and reception staff. We spoke to four patients, two of whom were members of the practice patient participation group (PPG) and observed how staff communicated with patients who visited or telephoned the practice on the day of our inspection. We reviewed six Care Quality Commission (CQC) comment cards that had been completed by patients and looked at the records the practice maintained in relation to the provision of services. We also spoke to attached staff that worked closely with, but were not employed by, the practice.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff were well aware of their roles and responsibilities in reporting and recording significant events. The practice had an up to date significant event policy and reporting form
- Significant events were analysed and reviewed regularly at clinical business meetings and findings disseminated to non-clinical if appropriate.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an issue where a patient had been left on a particular treatment regime when it was no longer necessary led to an audit and review of patients receiving the same treatment, alerts being placed on patient records and consideration given to employing a clinical pharmacist.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had a number of clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, there were also areas where improvements were required.

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to level three in respect of safeguarding children.
- A notice in the waiting room advised patients that chaperones were available if required. Staff who acted as chaperones had received appropriate training and a Disclosure and Barring Service (DBS) check (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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy and a comprehensive cleaning schedule was in place. The practice did not have a formal system in place in respect of carrying out infection control audits but we were told that the practice carried out regular informal 'walk around' infection control audits during which any issues were identified. The practice told us that as a result of such an audit they had decided to review their cleaning schedule. Not all staff had received infection control training. However, the practice had recently purchased an on-line training package and all staff were due to undertake the infection control training module.
- An effective system was in place for the collection and disposal of clinical and other waste.
- The practice did not have an effective system in place to deal with patient safety alerts or updates. A designated person had not been identified to process the alerts and there was no system in place to ensure these had been read or acted upon. The operational manager told they were aware that the process needed strengthening and intended to do so in the very near future.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice generally kept patients safe and there were good processes in place for ensuring emergency and dispensary medicines were stored securely and appropriately. However, we did find that despite having a checklist of expiration dates for medicines held in GP bags that some of these were out of date. One ampule of medicine had expired in April 2015 and some syringes had expired in September 2015. In addition, although there was an effective system in place to ensure the expiration dates of medicine stocked in the dispensary where checked regularly there did not appear to be an effective stock control system in place. Dispensary staff told us that they hoped to address this issue by

introducing a barcoded stock control system using the practice computer software. The practice had an effective Standard Operating Procedure in place for dispensary staff to follow.

- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. A Patient Group Direction allows registered health care professionals, such as nurses, to supply and administer specified medicines, such as vaccines, without a patient having to see a doctor
- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. All staff had either had appropriate checks through the Disclosure and Barring Service (DBS) or were undergoing checks at the time of our inspection.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and staff were aware of their roles and responsibilities in relation to this. The practice had up to date fire risk assessments and had recently carried out a fire evacuation drill. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. All administrative staff had received training to enable them to cover each other's duties to aid business continuity. Practice GPs planned their annual leave well in advance The practice rarely used locum GPs but when this was necessary they tried to use ex practice registrars who were familiar with practice policies and procedures and known by the patients. An effective locum induction pack was in operation.

Arrangements to deal with emergencies and major incidents

The practice had good arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had received basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive disaster recovery plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date by discussing new guidance and protocols at fortnightly clinical meetings. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 98% of the total number of points available to them compared with the local clinical commissioning group (CCG) average of 97.6% and national average of 93.5%. At 13.2% their clinical exception rate (the QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect) was higher than the local CCG average of 9.3% and national average of 9.2%. Staff we spoke with felt the high exception reporting rate was related to the practices high proportion of elderly patients with comorbidities and patients living in more rural areas who had not responded to recalls for annual reviews.

- The practice had achieved 100% of the points available to them for a number of QOF indicators including asthma, cancer, dementia, depression, chronic obstructive pulmonary disease, hypertension and heart failure
- Performance for diabetes related indicators was higher than the local CCG and national averages (96.5% compared to the CCG average of 95% and national average of 89.2%).
- Performance for mental health related indicators was lower than average (80.8% compared with a CCG average of 96.5% and national average of 92.8%). Staff we spoke to explained that they felt this had been due to a gap in having an identified mental health lead. This gap had since been addressed.

The practice was able to demonstrate that it had carried out comprehensive clinical audit activity to help improve patient outcomes. We saw evidence of two cycle audits, including one used to review patients prescribed domperidone (a drug used to prevent nausea and vomiting) due to a potential side effect. The audit had resulted in the notes of 29 patients being reviewed and ten patients being contacted for a follow up review. We also saw evidence of audits to demonstrate good clinical governance and appropriate skill levels of clinical staff. This included a year long audit looking at post procedure complications following the insertion of intrauterine contraception devices. The practice had an effective prescribing and medication review policy which was regularly reviewed and updated.

The practice had a palliative care register and held regular multi-disciplinary palliative care and high risk patient meetings to discuss the care and support needs of these patients and their families.

Effective staffing

The staff team included medical, nursing, managerial, dispensary, administrative and cleaning staff. The partnership consisted of four GP partners. We reviewed staff training records and found that staff had received a range of mandatory and additional training. This included basic life support, health and safety, safeguarding and appropriate clinical based training for clinical staff. Gaps in training had been identified and the practice had purchased an on-line training package and were in the process of ensuring staff received training in areas such as information governance and infection control.

The GPs were up to date with their yearly continuing professional development requirements and had been revalidated (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). The practice nurses reported they were supported in seeking and attending continual professional development and training courses.

Good

Are services effective?

(for example, treatment is effective)

All staff had received an annual appraisal from which personal development and training plans were developed. The appraisals were linked to the aims and objectives of the practice.

We looked at staff cover arrangements and identified that there were sufficient GPs on duty when the practice was open. Holiday, study leave and sickness were covered in house whenever possible and holidays were planned well in advance. Steps had been taken to ensure administrative staff had all received training in each other's roles. The practice had an effective staff induction policy and a locum induction pack was in operation for locum GPs.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets was also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that formal multi-disciplinary team meetings took place on a monthly basis. The practice also held daily informal coffee break meetings which could be attended by practice staff and multi-disciplinary practitioners.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the 113 patients who participated in the National GP Patient Survey published in July 2015, 93.42% reported the last GP they visited had been good at involving them in decisions about their care. This compares to a national average of 81.4% and local clinical commissioning group average of 85.7%. The same survey revealed that 91.7% of patients felt the last nurse they had seen had been good at involving them in decision about their care compared with a national average of 84.8% and local CCG average of 87.3%.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients requiring palliative care, high risk patients, carers and those with a long-term and mental health condition or learning disability.

The practice's uptake for the cervical screening programme was 95%, which was higher than the national average of 81.8%. The practice had participated in a 'pink letter' pilot scheme with the Macmillan cancer support organisation to encourage more women to attend cervical screening.

Childhood immunisation rates were comparable with local CCG averages. For example, childhood immunisation rates for the vaccinations given to two year olds ranged from 93.9% to 98.8% (compared with the CCG range of 95.3 to 98.1%). For five year olds this ranged from 91.4% to 98.9% (compared to CCG range of 94.9% to 100%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for people aged 40–74 and over 75 health checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. 932 (87%) of the practices 1070 patients over the age of 75 had received an over 75 health check. The practice had also carried out 250 NHS Health Checks and a further 157 NHS Health Check reviews.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

- Curtains were provided in consulting 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.
- Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received six completed CQC comment cards, the majority of which were very complementary about the practice. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. We also spoke with four patients during our inspection, two of whom were members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. The practice scored above local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 99.3% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.1% and the national average of 95.2%.
- 94.9% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.2% and the national average of 85.1%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98.6% and the national average of 97.1%.
- 97.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92.9% and the national average of 90.4%.
- 92.6% patients said they found the receptionists at the practice helpful compared to the CCG average of 88.6% and the national average of 86.8%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patient satisfaction was above average in relation to questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages. For example:

- 92.9% said the GP was good at listening to them compared to the CCG average of 90.6% and the national average of 88.6%.
- 89.7% said the GP gave them enough time compared to the CCG average of 88.8% and the national average of 86.6%.
- 94.2% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.3% and the national average of 86%.
- 93.4% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85.7% and the national average of 81.4%.
- 99.3% said the last nurse they spoke to was good listening to them compared to the CCG average of 93.4% and the national average of 91%.
- 97.4% said the nurse gave them enough time compared to the CCG average of 94.5% and the national average of 91.9%.

The practice had access to a translation service for patients who did not have English as a first language; however although this was advertised in the practice information leaflet the service was not advertised in the practice reception area. The practice did not have a hearing loop to assist patients with hearing difficulties.

Good

Are services caring?

The practice were not able to demonstrate that they were pro-actively identifying or supporting carers. However work was ongoing to ensure that information for carers was included on the practice website. In addition, the practice patient participation group had identified this as an area for development and had taken the lead in ensuring information for carers was displayed in the waiting rooms and in distributing the local carers association newsletter to clinical staff for distribution to relevant patients.

The practice had identified a nursing lead for patients with a learning disability. Patients with a learning disability were offered an annual health check and vaccinations.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room and on the practice website told patients how to access a number of support groups and organisations.

Steps were being taken to try and ensure carers were identified pro-actively rather than opportunistically. When carers were identified they were signposted to the local carers centre for help and support.

The practice signposted patients requiring support as a result of a bereavement to the local talking therapies service and provided a room for the service to use.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had reviewed the needs of their local population planned services accordingly. Services took account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care.

- Home visits were available for older patients, housebound patients and patients who would benefit from these.
- Longer appointments were routinely offered when required. This included elderly patients with complex conditions or those with complex mental health issues or a learning disability
- The practice was pro-active in its approach to monitoring and treating patients who were care home residents and at high risk of admission to hospital. A lead GP attended a monthly multidisciplinary meeting at a local care home to discuss and plan services to support such patients
- The practice also maintained a list of patients at risk of admission to hospital who were discussed at monthly multidisciplinary meetings held at the practice. This included elderly patients recently discharged from hospital, patients who had several hospital admissions during a short space of time and selected patients experiencing long term conditions such as chronic obstructive pulmonary disorder and ischaemic heart disease.
- There were disabled facilities and translation services available. The practice did not have a hearing loop
- All patient facilities were easily accessible to patients with a mobility issue.
- The practice offered online services such as being able to book an appointment or request a repeat prescription. The practice were introducing a text message appointment reminder system to help to reduce the number of patients who failed to attend their appointment
- The practice was a dispensing practice for patients who lived in more rural areas with limited access to a pharmacy. The practice had established a prescription delivery system to some local post offices.

Access to the service

The practice was open from 8am to 6pm on a Monday to Friday with appointments being available from 8.10am to 10.30am and 3pm to 5.20pm. The practice was also open after 6pm on Tuesday and alternate Wednesday evenings for pre bookable appointments only.

Results from the National GP Patient Survey published in January 2016 showed that patient's satisfaction with how they could access care and treatment was good when compared with local and national averages.

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 73%.
- 91% of patients said they could get through easily to the surgery by phone compared to the CCG average of 78% and the national average of 73%.
- 90% of patients described their experience of making an appointment as good compared to the CCG average of 86% and the national average of 85%.
- 81% of patients said they usually waited less than 15 minutes their appointment time compared to the CCG average of 67% and the national average of 58%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.

People told us on the day of the inspection that they were able to get a routine appointment within a reasonable timescale.

Practice GPs also covered the minor injuries unit at the local hospital which was based on the same site as the practice. The practice felt that this aided continuity of care for patients registered at their practice.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The 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 in the practice and on the practice website to advice patients how to make complaints. However, this information needs revising to advise complainants that they are able to

Good

Are services responsive to people's needs?

(for example, to feedback?)

escalate their concerns to the Parliamentary Health Service Ombudsman should they remain dissatisfied with the investigation into or response to their complaint.

The practice had recorded eight complaints during the period 1 January 2015 to the date of our inspection. We found that these had been satisfactorily handled, dealt with in a timely way and apologies issued when necessary. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care.

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 documented mission statement which was:

'To provide high quality care and a friendly working environment'

Their aims and objectives, as stated in their statement of purpose included:

- To provide excellent patient care delivered in a clean suitably equipped and safe environment
- To treat all patients and users of the practice with dignity and respect
- To ensure patients are involved in their own care and be given the appropriate choices in who, where and when their care is provided.

The practice did not have a formal business plan but practice management told us that forward planning, including ongoing succession planning was regularly discussed at strategy meetings. Leadership priorities for the year included resuming being a training practice, achieving financial stability and either recruiting another GP or looking at alternative ways to maintain an effective service if this was not possible.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and a verbal and/or written apology

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings. There was evidence of minuted monthly administrative team meetings and alternate weekly clinical/business meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. They proactively sought patients' feedback and engaged patients in the delivery of the service.

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received.

There was a small but active PPG which met every 3-6 months. They had been involved in increasing awareness of online patient services, promoting information for carers and analysing patient survey results. Priorities identified for

Are services well-led?

Good

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

future work included adding a section about services for carers to patient surveys, educating patients on the appropriate local health services for their needs, increasing membership of the PPG and continuing to promote on line services.

Continuous improvement

The practice had been through a period of instability over the previous two years due to issues with staff retention as a result of retirement, sick leave and resignation. The practice had commissioned an external provider to carry out a capacity and demand survey. This demonstrated that 17% of patients were unable to get a routine appointment within two weeks of requesting one and that practice GPs were routinely working longer than what was considered to be the average. The practice had therefore identified ways to achieve stability and improve appointment availability which they were in the process of considering. This included the introduction of a GP triage system, improving nursing capacity, upskilling current nursing staff and employing nurse practitioners. They were also committed to securing the appointment of additional GPs.

By their own admission the practice had made numerous improvements over the previous six months which had included agreeing practice aims and objectives, implementing a schedule of staff meetings and appraisals, purchasing an online mandatory training package for staff and introducing online access for patients.

There was evidence that the practice was seeking to continually improve and embrace new initiatives and ways of working which would enable them to do so. Following the resignation of the previous practice manager the practice had employed an operational manager on a secondment basis from the local primary care trust. They felt that this had led to improvements in links between the practice and secondary care providers. Staff had been able to participate in personal development opportunities, such as attendance at management courses and undertaking phlebotomy training. One of the practice GPs was undertaking a leadership course.