Meadowbrook Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

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

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. We also inspected the quality of care for six population groups which were, people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health. We rated the care provided to these population groups as good.

Our key findings were as follows:

- There were systems in place to ensure patients received a safe service. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, reviewed and addressed.
- There were effective arrangements in place to identify, review and monitor patients with long term conditions. Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with dignity and respect and they were involved in their care and decisions about their treatment.
- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups. The complaints procedure was accessible to patients.
- There was visible leadership with defined roles and responsibilities and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- The practice had taken action to improve the management and treatment of diabetic patients. The practice had employed a diabetic nurse specialist who

Summary of findings

worked in conjunction with one of the GPs and established a dedicated diabetic clinic two days a week. To date, 130 patients had been discharged from the hospital diabetic clinic and 280 patients were under the sole care of the practice.

- The practice had taken action to improve the number of patients aged between 40 years and 74 years who received the NHS health check. An audit had been undertaken and a protocol developed. The practice undertook a targeted approach which included the appointment of a Health Care Assistant to undertake the check. This significantly increased the number of NHS health checks offered and the practice went from a completion rate of 8% to 80% within a 10 month period. This resulted in the practice being rate within the top 5% of practices for completion of the check within the Clinical Commissioning Group (CCG).
- The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen. The practice had a system in place for offering choose and book which enabled 95% of patients to walk away with an appointment for their chosen hospital on the same day they were seen by the GP.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Develop a policy for significant events for staff to follow to ensure a consistent approach.
- Ensure appropriate signage is in place to alert people of the risks associated with flammable liquids and oxygen.
- Ensure reasonable adjustments are made to enable people who require the use of a wheelchair are able to access the service.
- Proactively undertake dementia screening for patients to ensure early identification and intervention.

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 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 good for providing effective services. Data showed patient outcomes were average in comparison to other practices nationally for a number of areas. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely.

Clinical audits were completed to ensure patients' care and treatment was effective. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and further training needs had been identified and were planned for. There was evidence of appraisals and personal development plans for all staff. There was evidence of effective multidisciplinary working to ensure a coordinated approach to managing people with complex, long term conditions and those in high risk groups.

The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen. The practice had a system in place for offering choose and book which enabled 95% of patients to walk away with an appointment for their chosen hospital on the same day they were seen by the GP.

Are services caring?

Good

The practice is rated good for providing caring services. Data showed that patients rated the practice as average in comparison to other practices nationally for several aspects of care. The practice was higher than the national average for the proportion of patients who would recommend the practice. Patients said they were treated with compassion, dignity and respect. Patients told us that staff listened and gave them sufficient time to discuss their concerns and they were involved in making decisions about their care and treatment. Information to help patients understand the services was available and easy to understand.

Summary of findings

Are services responsive to people's needs?

Good

The practice had arrangements in place to respond to the needs of specific patient groups. There were vaccination clinics for babies and children and women were offered cervical cytology screening. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated. Patients were able to access urgent appointment usually on the same day.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated good for providing well-led services. It had a vision and strategy and staff were aware of their responsibilities in relation to this. There was visible leadership with defined roles and responsibilities and staff felt supported by management. The practice had a number of policies and procedures to govern activity. The practice had systems in place to monitor its performance in areas such as the Quality Outcome Framework (QOF). The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. 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 good for the care of older people. Nationally reported data showed that outcomes for patients were overall good for conditions commonly found in older people. The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, end of life care. It was responsive to the needs of older people, and offered home visits. The practice worked in conjunction with the multidisciplinary team to identify and support older patients who were at high risk of hospital admissions. However, the practice should proactively undertake dementia screening for patients to ensure early identification and intervention.

People with long term conditions

Good

The practice is rated good for the care of people with long-term conditions. Nursing staff had lead roles in the management of long term conditions. The practice had taken action to improve the management and treatment of diabetic patients. The practice had employed a diabetic nurse and had a dedicated diabetic clinic which had reduced the number of patients attending the hospital diabetic clinic. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and an 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. Patients with long term conditions were added to the appropriate registers so that they could be easily identified and offered regular reviews of their health needs.

The practice offered a same day service for repeat prescriptions ordered by 1pm and we saw evidence that all of these prescriptions had been issued on the same day.

Families, children and young people

Good

The practice is rated good for the care of families, children and young people.There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of

Summary of findings

A&E attendances. Appointments were available outside of school hours. There was evidence of joint working arrangements with the midwives and health visitors and systems in place for information sharing.

Working age people (including those recently retired and students)

Good

The practice is rated good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice was open early mornings and late evenings to accommodate the needs of patients who worked.

The practice had taken action to improve the number of patients aged between 40 years and 74 years who received the NHS Health Check by undertaking a targeted approach. This included the appointment of a Health Care Assistant to undertake the check. This significantly increased the number of NHS health checks offered and the practice went from a completion rate of 8% to 80% within a 10 month period. This resulted in the practice being rate within the top 5% of practices for completion of the check within the Clinical Commissioning Group (CCG).

People whose circumstances may make them vulnerable

Good

The practice is rated 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 and those with caring responsibilities. It had carried out annual health checks for people with a learning disability and offered longer appointments .The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of contacting relevant agencies in normal working hours and out of hours.

The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical services contract (GMS).

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. Staff worked closely with local community mental health teams who undertook regular clinics at the practice to ensure patients were reviewed, and that appropriate risk assessments and care plans were in place.

Summary of findings

What people who use the service say

We looked at the results of the 2013-2014 national GP patient survey. Findings of the survey were based on comparison to other practices nationally. The results showed that overall the practice performance in areas relating to access was average. This included the practice opening times, phone access and the proportion who stated that they always or almost always see or speak to the GP they prefer. Patients feedback on staff treating them with care and concern and involving them in decisions about their care was also similar to other practices nationally. The practice was higher than the national average for the proportion of patients who would recommend the practice.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were three comments posted on the website in the last year, these were all positive and included that staff were helpful and polite and appointments that were accessible.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 13 completed cards. The feedback we received was positive overall. Patients described staff who were polite and helpful and took time to discuss and explain their health needs.

On the day of the inspection we spoke with five patients including two members of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients told us that they were involved in their care and staff took time to explain their treatment in a way that they understood.

Areas for improvement

Action the service SHOULD take to improve

- Develop a policy for significant events for staff to follow to ensure a consistent approach.
- Ensure appropriate signage is in place to alert people of the risks associated with flammable liquids and oxygen.
- Ensure reasonable adjustments are made to enable people who require the use of a wheelchair are able to access the service.
- Proactively undertake dementia screening for patients to ensure early identification and intervention.

Outstanding practice

- The practice had taken action to improve the management and treatment of diabetic patients. The practice had employed a diabetic nurse specialist who worked in conjunction with one of the GPs and established a dedicated diabetic clinic two days a week. To date, 130 patients had been discharged from the hospital diabetic clinic and 280 patients were under the sole care of the practice.
- The practice had taken action to improve the number of patients aged between 40 years and 74 years who received the NHS health check. An audit had been undertaken and a protocol developed. The practice undertook a targeted approach which included the appointment of a Health Care Assistant to undertake the check. This significantly increased the number of NHS health checks offered and the practice went from a completion rate of 8% to 80% within a 10 month period. This resulted in the practice being rate within the top 5% of practices for completion of the check within the Clinical Commissioning Group (CCG).
- The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen. The practice

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had a system in place for offering choose and book which enabled 95% of patients to walk away with an appointment for their chosen hospital on the same day they were seen by the GP.

Meadowbrook Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a specialist advisor GP and a specialist advisor practice manager with experience of primary care services.

We were also supported on this inspection by an expert-by-experience. This is a person who has personal experience of using this type of service.

Background to Meadowbrook Surgery

Meadowbrook Surgery is a three GP partnership practice based in a purpose built single-storey building. The registered patient list size is approximately 7500 patients.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice also provides some enhanced services. An enhanced service is a service that is provided above the standard general medical services contract (GMS).

Meadowbrook Surgery is open Mondays, Tuesdays, Wednesdays and Fridays between 8:30am and 6pm. The practice is closed at 12pm on Thursdays however, patients can access general medical services on Thursday afternoons by contacting 'Primecare' which is an out-of-hours service provider.

The practice has opted out of providing out-of-hours services to their own patients. When the practice is closed outside of core hours the answerphone message informed patients to call the either the emergency service 999 or the NHS 111 service which would assess and refer patients to the out-of-hours services.

The staffing establishment at Meadowbrook Surgery includes clinical staff compromising of three GP partners (all male) one practice nurse (female) one diabetic nurse (female) and one health care assistant (female). There are seven administrative/reception staff and a practice manager. As there were only male GPs employed at the practice there were arrangements in place with a local GP practice where female patients could be referred to if they wished for example, for family planning services.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in an area with a low deprivation score compared to other practices nationally. Data showed that the practice has an above average practice population aged 65 years and over and a lower than the average practice population aged 0 to 4 years in comparison to other practices nationally. The practice has a higher than the national average number of patients with caring responsibilities with a rate of 22.8% compared to the national average of 18.5%.

The practice achieved 93.3 points for the Quality and Outcomes Framework (QOF) for the financial year 2012-2013. This was slightly below the national average of 96.4. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

This provider was inspected using our previous methodology on 7 January 2014. The provider was not meeting regulations 10,11,12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. These related to assessing and monitoring the quality of service

Detailed findings

provision, safeguarding and cleanliness and infection control. This comprehensive rated inspection included a follow up of the outstanding actions from the previous inspection.

Why we carried out this inspection

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice. We also asked other organisations to share what they knew. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 13 completed comment cards where patients shared their views and experiences of the service. We carried out an announced visit on 28 January 2015. During our inspection we spoke with a range of staff including the management team, clinical and non clinical staff. We spoke with patients who used the service and observed the way the service was delivered.

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 used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw an example of a medication error that was reported, well documented and appropriate action taken.

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

Learning and improvement from safety incidents

At our last inspection in January 2014 we found there was no policy or procedure for serious incidents that may cause harm. Some staff members we spoke with were unclear of what required reporting. During this inspection we saw that the practice had a system in place for reporting, recording and monitoring significant events which included serious incidents that may cause harm. Staff were aware of the procedure for reporting. We saw that there were four significant events that had occurred during the last year and we were able to review these. There was evidence that the practice had learned from these, action taken and that the findings were shared with relevant staff. We saw evidence of actions taken and changes made a result of a significant event to prevent re occurrence. For example, ensuring patients' electronic and paper records were cross referenced before administering vaccinations. However, the practice did not have significant event policy to provide guidance to staff and ensure a consistent approach was maintained.

Significant events were discussed at regular clinical meetings and also shared with non clinical staff where relevant in weekly practice meetings. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were circulated by the practice manager using an electronic alert system and stored on a shared drive. This ensured they were acted on where appropriate and shared with staff and provided a clear audit trail. Patient safety alerts are issued when potentially harmful situations are identified and need to be acted on.

Reliable safety systems and processes including safeguarding

At our last inspection in January 2014, we saw that there were no policies for safeguarding and training for staff was in progress. During this inspection we saw the practice had systems to manage and review risks to children and vulnerable adults. Policies and procedures for safeguarding children and vulnerable adults were in place to support and guide staff. There was evidence that since our last inspection all of the staff had now received training in safeguarding children and vulnerable adults relevant to their role. Staff spoken to knew how to recognise signs of abuse were aware of their responsibilities and knew how to share information, record concerns and contact the relevant agencies in working hours and out of normal hours. We saw that contact details were easily accessible.

There were no formal meetings with the health visiting team. However, the health visiting team undertook weekly clinics at the practice and this provided the opportunity to share information and concerns about at risk children.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone poster which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting

Good

Are services safe?

as chaperones. However, non clinical staff did not have a Disclosure and Barring Service (DBS) check or a risk assessment in place. The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. The practice manager told us that potential risks had been considered although not formally documented and that non clinical staff were never left unattended with the patient. Following our inspection we were provided evidence that DBS checks had been completed for all non clinical staff.

Medicines management

There were two dedicated secure fridges where vaccines were stored. There were systems in place to ensure that regular checks of the fridge temperatures were undertaken and recorded. Both fridges had data loggers that ensured temperature recordings could be audited. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use. The practice had also purchased specific storage bags that would ensure safe transportation of vaccinations in the event this was required and ensure that the cold chain was maintained. A cold chain policy was in place to guide and support staff and ensure consistency.

The practice routinely used electronic prescribing and systems were in place to ensure all prescriptions including paper prescriptions could be accounted for.

There were arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure their medications remained relevant to their health needs. The practice offered a same day service for repeat prescriptions ordered by 1pm and we saw evidence that all of these prescriptions had been issued on the same day.

The practice had undertaken several medicine audits for example to ensure patients on a particular medicine were followed up to review their progress. Findings from the audits had been acted to ensure improved outcomes for patients.

National prescribing data available to us for 2013-2014 showed us that the practice prescribing rates for some medicines for example, the prescribing of Non-Steroidal Anti-Inflammatory medicines were in line with the national average. The practice rates for antibacterial prescriptions were better than the national average.

Cleanliness and infection control

At our last inspection in January 2014, we identified that the practice needed to further develop systems to protect patients from the risks of infection. Staff were unaware of the latest Department of Health guidance on infection prevention and control and had not received training. Audits had not been carried out to ensure infection prevention measures were in place. The practice did not have a designated infection control lead for the practice.

During this inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment and posters promoting good hand hygiene. There was an infection control policy and a named lead for infection control with responsibility for overseeing good infection control procedures. We saw evidence that all of the staff had received training in infection prevention and control so that they were up to date with good practice.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed to help staff monitor how long they had been in place. A contract was in place to ensure the safe disposal of clinical waste.

The practice employed cleaners for the general cleaning of the environment and there were records to demonstrate the cleaning undertaken. Spot checks were undertaken by the management team to ensure standards of cleaning were being maintained.

An infection prevention and control audit had been completed by the practice in January 2015 and there was evidence that most of the actions identified from the audit had been addressed and others were in progress. For example, the practice was replacing the carpet in the GP consulting rooms with impervious flooring within the month following our inspection.

The practice had completed a Legionella risk assessment in November 2014. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

We saw that there were areas in the practice that were cluttered and it was evidence that there was limited storage space. This was an issue that was being addressed by the practice and included a major clear out in February 2015, when new flooring was due to be laid.

Good

Are services safe?

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 were visually checked by the practice manager every six months. However, they had not been tested and no schedule of testing was in place. Following our inspection we received confirmation that testing of electrical equipment had taken place.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring

Service (DBS). A DBS check helps to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had a recruitment policy that set out the standards followed when recruiting staff. However, the policy did not make reference to any requirements for a DBS check.

The practice manager told us that 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. There was evidence to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We saw that there were effective arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. A rota system was in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for nursing and administrative staff, to cover each other's annual leave. The practice had not utilised any locum GPs in the last 18 months as the GPs covered each other's annual leave.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. At our last inspection in January 2014 we identified that staff had not received fire safety training. During this inspection we saw that staff had received recent fire safety training. There was evidence that regular fire drills took place to ensure staff were prepared in the event of a fire emergency. Fire equipment and alarms were checked to ensure they were in good working order. A fire risk assessment had been completed in August 2014. However, we saw that the room where emergency oxygen was stored did not have a sign warning of the risks associated with flammable liquids and oxygen.

The practice had a policy and data log sheets for the control of substances hazardous to health (COSHH) to ensure an accurate record of all COSSH products.

Arrangements to deal with emergencies and major incidents

There were arrangements to deal with foreseeable medical emergencies. Staff had received training in responding to a medical emergency. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely in the event of a medical emergency. We checked the expiry date of a sample of the medicines and saw that they were in date. We saw that there were records kept of the checks undertaken of the emergency medicines. The practice also had oxygen and automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff asked (including receptionists) knew the location of the emergency medicines and equipment. However, there were no records kept of the checks undertaken of the oxygen and AED. We also saw that emergency medicines, oxygen and the AED were stored in areas that were accessible to patients. We discussed this with the practice manger and GPs at the time of the inspection who told us that this would be addressed.

At our last inspection in January 2014 the practice did not have emergency plan in the event of power failure and other foreseeable emergencies. During this inspection we saw that the practice had 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 for example, power failure and adverse weather The document also contained relevant contact details for staff to refer to and was easily accessible to all staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could 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).

Regular clinical meetings and protected learning time provided the opportunity to discuss and share best practice.

At our last inspection in January 2014 there were a number of areas in the Quality Outcomes Framework (QOF) that the practice was not meeting in relation to chronic disease management such as diabetes and mental health. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some long term conditions, for example asthma and diabetes. During this inspection we saw that the practice had an effective system in place for identifying and reviewing patients with long term conditions. National data for the year 2013-2014 showed that the practice was in line with the national average in areas such as mental health and learning disabilities. The practice was below the national average for some areas of diabetic care for the year between 01/04/2013 and 31/03/2014. For example, the percentage of patients with diabetes, on the register, with a record of a foot examination within the preceding 12 months. The practice score was 0.4 compared to the national average of 0.8. The practice score for percentage of patients with diabetes, on the register, who had a record of an albumin: creatinine ratio test in the preceding 12 months was 0.5 compared to the national average of 0.8. However, we saw evidence that the practice had taken action to improve the management and treatment of diabetic patients. The practice had employed a diabetic nurse specialist who worked in conjunction with one of the GPs and established a dedicated diabetic clinic two days a week. At the time of our inspection 130 patients had been discharged from the hospital diabetic clinic and 280 patients were now under the sole care of the surgery. This meant for example, that 83% of patients had received a foot examination in the last 12 months.

The practice used national standards for any urgent referrals to secondary care for example for suspected cancer.

Discrimination was avoided when making care and treatment decisions. Interviews with the GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients as part of the QOF. The practice achieved 93.3 points for the QOF for the financial year 2012-2013. This was slightly below the national average of 96.4.The practice QOF score in areas such as mental health, flu vaccinations; cervical cytology screening were average in comparison to other practices nationally. There was evidence that the practice was pro-actively monitoring its QOF targets with effective systems in place to call and recall patients. This included a monitoring system to review QOF targets on a monthly basis and develop actions for key areas The practice was using the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had identified and taken action to improve the management and treatment of diabetic patients in a response to a below national QOF score for diabetes.

The practice had a system in place for completing clinical audit cycles. The practice had completed seven clinical audits in the last year. These were completed cycles which showed improvements made to patients care and treatment. For example, an audit to ensure patients who were prescribed a particular medicine received appropriate blood tests and follow up. Other examples included audits to confirm that the GPs who undertook minor surgical procedures (joint injections) were doing so in line with their registration and NICE guidance.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

The practice had implemented the gold standards framework for end of life care (GSF). This framework helps doctors, nurses and care assistants provide a good

Good

Are services effective?

(for example, treatment is effective)

standard of care for patients who may be in the last years of life. This included a palliative care register and regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Childhood vaccinations were undertaken by the practice nurse. There were systems in place to identify and follow up children who did not attend and these included discussions with the health visitor. National data for the year 2013 showed that the practice performance for childhood vaccinations were above the Clinical Commissioning Group (CCG) average. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Effective staffing

The practice had an established team that included medical, nursing and administrative staff. We saw that most staff were up to date with courses such as basic life support, safeguarding children and vulnerable adults, fire safety and infection control. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, cervical cytology and diabetes.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training.

There were weekly practice meetings which included staff such as administrative and clinical staff which enabled important information to be shared with staff as well providing an opportunity or staff to discuss any issues. The GPs also had two weekly clinical meetings.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were systems in place to ensure that the results of tests and investigations were reviewed and actioned on as clinically necessary by a GP. The practice had an effective referral system to secondary care services.

Multidisciplinary working was in place, and meetings were held with health care professionals .We spoke with the midwife and community mental health team who told us that there were systems in place to ensure share important information. We also spoke with the manager of a local care home for people with learning disabilities. They provided positive feedback on how accommodating and flexible the practice was in ensuring vulnerable people received the care and treatment that they needed. This included changing appointments at short notice, accommodating specific appointment times that were more suitable and undertaking home visits for reviews as well as for blood tests and flu vaccinations.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had completed the required 2% of care plans and regularly reviewed them.

Information sharing

The practice had arrangements in place to share information with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice referred patients appropriately to secondary and other community care services such as the mental health service. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen. The practice had a system in place for offering choose and book which enabled 95% of patients to walk away with an appointment for their chosen hospital on the same day they were seen by the GP.

Our discussion with health care professionals and evidence from meeting minutes reviewed on the day demonstrated that information was shared with partner agencies in a timely manner.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had a consent policy in place and there was a template to record capacity assessment which would be uploaded on to the patients medical records to provide an audit trail.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff demonstrated an understanding of Gillick competencies. (These helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Patients with a learning disability and those with mental health needs were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

Health promotion and prevention

Information leaflets and posters relating to health promotion and prevention were available in the patient waiting area.

The practice offered advice and support in areas such as smoking cessation, weight management, diabetes and sexual health referring patients to secondary services were necessary. A range of health promotion and screening services were offered which reflected the needs of the practice population for example childhood vaccinations, flu vaccinations for patients over the age of 65 years and high risk groups. There was a national recall system in place for cervical cytology screening in which patients were invited to attend the practice. Cervical cytology screening was undertaken by the practice nurse. This ensured women received this important health check including their results in a timely manner. Findings were audited to ensure good practice was being followed.

The NHS health check was offered to patients aged between 40 years and 74 years. The practice previously had a low achievement score for the check. As a result the practice manager liaised with the local public health team and undertook an audit. This resulted in the development of a protocol and a more targeted approach which included the appointment of a Health Care Assistant to undertake the check. This significantly increased the number of NHS health checks offered and the practice went from a completion rate of 8% to 80% within a 10 month period. This resulted in the practice being rate within the top 5% of practices for completion in the Clinical Commissioning Group area (CCG).

The practice had a policy and procedure in place for new patients registering with the practice. Patients were asked to complete a health questionnaire and then invited to attend an appointment with the practice nurse. The GPs were informed of all health concerns detected and these were followed up in a timely way.

The practice had a blood pressure machine in the nurses room for patients to check their own blood pressure. However, as the machine was stored in the nurses room it was only accessible when the nurse was on duty.

The practice had a website, however we found that information on the website was out of date. The practice manager told us of their plans to update the website.

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 2013-2014 national GP patient survey. The results of the national GP survey highlighted the practice was average in most areas in comparison to other practices nationally. For example, data showed the practice was rated average for the proportion of respondents who stated that the last time they saw or spoke to a GP or nurse, they were good or very good at treating them with care and concern. The practice was higher than the national average for the proportion of patients who would recommend practice with a value of 88 compared to the national average value of 79.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 13 completed cards. The feedback we received was overall positive overall. Patients described staff who were polite and helpful and took time to discuss and explain their health needs. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that their patients privacy and dignity was maintained during examinations, investigations and treatments. We also noted that consultation and treatment room doors were closed during consultations.

The layout of the patient waiting area meant that patient's confidentiality was not always maintained. Patients could be overheard when talking to staff at the reception desk as well as incoming calls taken by staff. However, we observed staff were careful in what they discussed with patients approaching the reception desk and a poster was on display informing patients that they could discuss any issues in private, away from the main reception desk. A glass screen was also in place to help minimise patients in the waiting room from overhearing incoming calls taken by reception staff.

Patients were offered a chaperone for intimate examinations and procedures and our discussions with staff demonstrated that they were aware of the importance of maintaining patient dignity and respect during such procedures. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

There were only male GPs employed at the practice. However, there were female practice nurses. The practice also had arrangements in place with a local GP practice where female patients could be referred to if they wished for example, for family planning services. This gave patients the option of receiving gender specific care and treatment.

Care planning and involvement in decisions about care and treatment

Data from the 2013-2014 national GP patient survey showed that patients rated the practice in line with other practices nationally in response to questions about their involvement in planning and making decisions about their care and treatment. For example, the numbers of respondents who said the last time they saw a GP or nurse they were good or very good at involving them in decisions about their care. This was aligned with feedback we received on the day of the inspection. Patients told us that they were involved in their care and decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The practice was proactive in identifying new patients registering at the practice who were carers. There was alert system on the patient record system to highlight these patients to staff. The practice also had a register so that carers were identified and support could be offered. GPs at the practice sign posted patients to various support groups. A carers leaflet was available with information about organisation to ensure this vulnerable group understood the various avenues of support available to them.

We saw that there were child bereavement leaflets in the patient waiting area that provided information to families affected by bereavement. Staff told us that if families had suffered bereavement, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients could also be referred for counselling if required.

Multidisciplinary working was in place, meetings were held with health care professionals such as the district nurses and the palliative care team part of the Gold Standard Framework (GSF) for end of life care. The GSF helps doctors, nurses and care assistants provide a good standard of care for patients who may be in the last years of life. National QOF data for the year 2013-2104 showed that the practice was below the national average for multidisciplinary team

Good

Are services caring?

meetings to discuss patients on the palliative care register. We spoke with the palliative care team who told us that there had been some gaps in meeting dates when the last practice manager left. However, since the appointment of the new manager there were monthly meetings that were well attended. They provided positive feedback about 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 patients' needs and had systems in place to maintain the level of service provided. The practice delivered core services to meet the needs of the patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as diabetes. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated. There were vaccination clinics for babies and children at risk groups, and women were offered cervical cytology screening.

National data from the Quality Outcomes Framework (QOF) for the year 2013-2014 showed that the practice performance in areas such as cervical cytology screening, flu vaccinations for at risk groups including those over 65 years were in line with national average. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some long term conditions, for example asthma and diabetes. There was evidence to support that the practice was monitoring its performance and taking action to ensure improvements were made. For, example, the practice had identified and taken action to improve the management and treatment of diabetic patients in a response to below national QOF scores for diabetes. The practice had also improved the uptake of the NHS health check offered to patients aged between 40 years and 74 years. The practice was below the national average for the ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD) and dementia diagnosis rate adjusted by the number of patients in residential care homes. The practice told us that although they had an above average practice population aged 65 years and over the patients were predominantly healthy however, they recognised the need to be more proactive in dementia screening. We saw evidence that the practice had made significant progress in a number of areas since the appointment of the current practice manager and further improvements were in progress.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example, the practice now offered the facility for patients to book their appointments online in response to patient request.

The practice had employed a diabetic nurse and ran a dedicated diabetic clinic. This enabled patients to be assessed and reviewed locally without the need to travel to the hospital.

Tackling inequity and promoting equality

Some of the GPs spoke second languages however, a translation service was available for patients who did not have English as a first language. Staff told us that the practice demographics meant that a translation service was not required very often.

There were baby changing facilities at the practice which would be helpful for parents with babies and young children.

There were accessible toilets facilities for patients with mobility issues and ramp access to the building. However, there were no automatic doors to the main entrance into the building and no designated disabled parking spaces. The practice had completed an audit in August 2014 to assess compliance with the Equality Act (2010). This Act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service. The audit had identified parking and the absence of automatic doors as areas for action. The plan was to have designated disabled parking spaces and to install a door bell to allow patients to call for assistance with the aim of completing the work by June 2015.

The practice manager told us that, at the time of our inspection, there were no patients registered at the practice with no fixed abode. We were told any new patients who were homeless and wanting to register would be able to do so.

Access to the service

Meadowbrook Surgery is open Mondays, Tuesdays, Wednesdays and Fridays between 8:30am and 6pm. The practice is closed at 12pm on Thursdays however, patients can access general medical services on Thursday afternoons by contacting 'Primecare'.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had opted out of providing out-of-hours services to their own patients. When the practice was closed outside of core hours the answerphone message informed patients to call the either the emergency service 999 or the NHS 111 service which assessed and referred patients to the out-of-hours services.

We looked at results of the 2013-2014 national GP patient survey. Findings of the survey were based on comparison to other practices nationally. The results showed that overall the practice performance in most areas relating to access was average. This included patients experience of getting through to the practice by phone, opening times and patients overall experience of their GP practice. Feedback from completed CQC comment cards were also aligned with these views. The practice had taken action to improve access by providing patients the option to book appointments and order prescriptions on line which was actively promoted. Resources had been increased to reflect patients needs and included the appointment of a diabetic nurse to run a dedicated diabetic clinic with one of the GPs and we saw that the uptake of this clinic was high. A health care assistant had been employed to undertake NHS health checks for patients aged between 40 years and 74 years. The practice had also made changes to the telephone system in response to call volumes which indicated that patients were experiencing difficulties in getting through on the phone to the practice. A review of the telephone system took place and as a result the number of lines were increased from four lines to six. The practice had also started a system where there were dedicated time slots for patients to receive the results of their blood test to reduce the length of time patients waited.

Telephone consultations were available with the GPs and nurses. Patients could book appointments in advance and urgent appointments were available on the same day. We looked at the appointment system which suggested good availability of appointments with the GPs despite the practice having a high patient to GP ratio.

Home visits were undertaken for those patients who were unable to attend the practice. We spoke with the manager of a local care home for people with learning disabilities. They provided positive feedback on how accommodating and flexible the practice was which included undertaking home visits for reviews as well as for blood tests and flu vaccinations.

Patients who required additional time were given longer appointments for example, patients with a learning disability.

The practice had a system in place to monitor and respond to patients that had not attended their appointment (DNA) to ensure effective use of resources. This included sending the patient a letter and inviting them to attend a meeting with the practice manager to discuss issues that maybe impacting on their ability to attend their appointment.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The complaints policy was displayed in the patient waiting area. Patients we spoke with had not ever needed to make a complaint about the practice but were aware of what to do in the event they did need to raise a complaint or concern.

The practice had received two complaints in the last 12 months which were handled satisfactorily and resolved. There was evidence that lessons learned from complaints were shared with staff with changes made.

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 care and promote good outcomes for patients. The practice values were clearly articulated to the inspection team and included treating patients fairly with dignity and respect, listening to patients and providing effective and safe healthcare. We saw areas of outstanding practice that supported the practices vision and aspirations.

Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice manager and GP partners had regular meetings to discuss the progress of the practice and areas for development. This provided an opportunity for detailed discussions and action plans to help facilitate improvements.

Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures for example, there were processes in place to keep staff informed and engaged in practice matters. This included protected learning time and regular staff meetings held to discuss significant events, complaints and share good practice.

The GPs at the practice had lead roles in specialist clinical areas such as safeguarding and mental health. This enabled staff to develop specialist knowledge and expertise and for other staff to obtain support and advice.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at some of these policies and procedures and found that most had been reviewed and were up to date.

There were systems in place to monitor and review the practice performance for Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. This included a GP lead for QOF and regular meetings to discuss and monitor performance. Data that we reviewed showed that the practice was on target to meet its points for the current financial year 2014 to 2015, for example people with long term conditions such as diabetes and learning disabilities.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits to help improve outcomes for patients on a particular medicine.

The GP partners at the practice attended meetings with the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. This ensured they were up to date with any changes.

Leadership, openness and transparency

Staff we spoke with told us that they felt listened to and said they felt comfortable to add anything they wish to discuss as an agenda for staff meetings or raise any concerns with the GPs or practice managers.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

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

At our last inspection in January 2014, the practice did not have a patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. During this inspection we met with two members of the PPG and they were positive about how the practice engaged with them and acted on feedback. There was evidence that the practice worked alongside the PPG and acted on patient feedback which had resulted in changes being made. For example, improving telephone access and providing baby changing facilities. Information about the PPG were displayed in the patient waiting area. The practice manager and a GP partner attended PPG meetings to ensure they remained fully involved and aware of feedback from patients.

The practice had participated in the NHS Friends and Family test. At the time of our inspection the practice had received 130 responses of these 83% were positive feedback and only 4% were negative.

Are services well-led?

Good

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

Patients had provided feedback on the NHS Choices website, these were all positive comments. The practice had not replied to any of the comments. We discussed this with the practice manager who told us they would be addressing this.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was evidence of training provided to staff to support their professional development. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

There was a visible leadership structure and staff members who we spoke with were clear about their roles and responsibilities. They told us that they felt valued, well supported and knew who to go to in the practice with any concerns. The practice manager had been in post about a year and had made a number of positive changes, they had also been nominated for the practice manager of the year at a CCG event.

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.