Barton Surgery

Quality Report

Lymington House
Torquay
TQ2 8JG
Tel: 01803 323761
Website: www.bartonsurgery-torquay.co.uk

Date of inspection visit: 06/05/2015
Date of publication: 02/07/2015

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 inspected Barton Surgery on 6th May 2015 as part of our comprehensive inspection programme. From all the evidence gathered during the inspection process we have rated the practice as good. The provider was rated as good for safe, responsive, caring, effective and well led services. It was also good for providing services for all of the population groups

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

• Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.

• The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example working in partnership with the local consultant geriatrician.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

• The practice implemented suggestions for improvements and made changes to the way it

delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

• 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.

• The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, which was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

Summary of findings

The practice supported its patients and their families throughout difficult times. GPs carried out bereavement checks with patient's relatives three months after the patient's death to check how the relative was coping and to see if they needed any additional support.

The practice supported vulnerable patients by delivering the Violent Patient Scheme (VPS) to vulnerable patients in Torbay and South Devon. This was a scheme that was in place to protect staff from incidents of violence and aggression and to provide access to primary medical services for patients whose violent and aggressive behaviour has caused them to be removed from the GP practice list.

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

In addition the provider should:

Update the practice handbook so that patients are aware the services offered by the practice and the opening times.

Introduce systems to ensure that portable equipment kept in GPs is routinely checked and testing equipment be kept in date.

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. This practice was safe and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to other practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on.

The practice supported its patients and their families throughout difficult times. GPs carried out bereavement checks with patient's relatives three months after the patient's death to check how the relative was coping and to see if they needed any additional support.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The appointment system was flexible and was regularly reviewed to enable people to

Summary of findings

access care and treatment when they needed it. The practice worked in partnership with other providers and organisations to meet patients' needs in a responsive way. The practice had good facilities and was well equipped to treat patients and meet their needs. Patients concerns and complaints were listened and responded to and used to improve the service.

Are services well-led?

Good

The practice is rated as good for providing well-led services. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

GP's had direct access to a care of the elderly consultant for advice on the best treatment and whether it was appropriate for the patient to stay in the community. The GPs were able to refer patients to the care of the elderly consultant's rapid access clinics.

Data showed that 91% of patients received structured annual medication reviews for polypharmacy in the last year. The GPs worked with a pharmacy assistant (provided by the CCG medicines optimisation team) who visited the practice on a regular basis to review the prescribing data. This included running appropriate audits, assessing the prescribing data in comparison with local and national standards and feeding back to the whole practice on a regular basis.

Pneumococcal, influenza and shingles vaccination were provided at the practice for older people.

Having identified that many people with dementia remain undiagnosed, one of the GPs visited and screened patients in residential homes at risk of dementia and identified nine new cases, a 20% increase in numbers diagnosed at Barton surgery.

The practice is all on one level with lift access. Chairs in the waiting room include some with arm rests to assist patients to stand. They had a hearing loop fitted in reception, and a wheelchair on site. Staff had received training from the Alzheimer society and Torbay Dementia Alliance.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. All patients were offered an annual review including a review of their medication, to check that their health needs were being met. When needed, longer appointments and home visits were available. Where possible, clinicians reviewed patient's long term conditions and any other needs at a single appointment, to prevent them from attending various reviews. Emergency processes

were in place and referrals were made for patients that had a sudden deterioration in their health. For those people with the most complex needs, a named GP worked with relevant health and care professionals to deliver multidisciplinary support and care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families who were at risk. Staff were knowledgeable about child protection and proactive in raising concerns with the safeguarding lead to follow up on any identified. A GP took the lead for safeguarding with the local authority and other professionals to safeguard children and families.

Children and young people were treated in an age-appropriate way and were recognised as individuals. We saw that staff dealing with young people under 16 years of age without a parent present were clear of their responsibilities to assess Gillick competency. Sexual health, contraception advice and treatment were available to young people including chlamydia screening. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors who were based at the practice. Health visitors had access to the clinical system so notes could be made on records, or progress checked, easily. Immunisation rates were high for all standard childhood immunisations.

A primary care CAMHS (Children and Mental Health Service) worker held a clinic each week in the practice. During the clinic they had open access to GP's for advice and or referral.

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 identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice provided travel advice and nurse led travel clinics within the practice. They were a designated Yellow Fever Vaccine Centre, so providing travel advice to patients who were not registered with this practice.

Summary of findings

There was an easy to use appointment system, which supported patient choice and enabled the patients to access the right care at the right time. Extended hours telephone appointments were available each evening and pre-bookable face to face appointments on a Saturday morning.

There were telephone appointments available throughout the day rather than needing to attend the practice for face to face consultations. Patients had e-mail access to GP's, and could book appointments by telephone, in person or on line. The practice used a text message reminder service for patients.

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 people with learning disabilities. Patients with a learning disability were offered an annual health review, including a review of their medication. When needed longer appointments and home visits were available. The practice was part of a local scheme to support the most vulnerable patients with the aim of managing their needs at home and avoiding unplanned hospital admissions. The practice worked with multi-disciplinary teams in the case management of people in vulnerable circumstances and at risk of abuse.

The practice supported vulnerable patients by delivering the Violent Patient Scheme (VPS) to vulnerable patients in Torbay and South Devon. This was a scheme that was in place to protect staff from incidents of violence and aggression and to provide access to primary medical services for patients whose violent and aggressive behaviour has caused them to be removed from the GP practice list.

Barton Surgery were working with the Citizens Advice Bureau on an initiative which involved a caseworker working in partnership with primary health teams at Barton surgery. They aimed to provide home visits to carers, disabled adults, families with children with disabilities and the frail elderly on complex non-medical issues. The aim of the post was to develop a linked, co-ordinated and holistic approach to support the carer (and cared for) to live well within their community through enabling better access to specialised advice, information, knowledge, skills, relationships and resources.

Patients with substance abuse problems could be referred or directed to open access clinics locally. GP's could refer patients or encourage them to refer themselves to a primary care alcohol service.

Summary of findings

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. The practice held a register of patients experiencing poor mental health. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, to ensure their needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients were supported to access emergency care and treatment when experiencing a mental health crisis. Patients could be referred or refer themselves to the depression and anxiety services (DAS). DAS offered to see patients within the practice or at alternative venues where appropriate. Patients with mental health problems were encouraged to attend an annual review to include a discussion and review of their care plan and medicines.

Mental health medication reviews were conducted to ensure patients received appropriate doses, and blood tests were performed on patients receiving certain mental health medications.

The local consultant psychiatrist regularly attended practice meetings to ensure referral pathways and communication between the service and GP's worked well, and to discuss individual cases where appropriate.

Summary of findings

What people who use the service say

On the day of our inspection we received 34 comment cards, which had been completed in a two week period before the inspection date. All of the comments we received were positive about the

experience of being a patient registered at the practice. There was a recurrent theme of patients saying that they were treated with support and care. We also spoke with 12 patients and their views aligned with the comments in the cards we received. Patients gave us positive examples of treatment they received and support offered by practice staff. All said they were treated with dignity, respect and kindness by staff.

Results from the most recent GP national patient survey in January 2015 stated that 88% of 151 patients that returned their survey rated their overall experience of the practice as at least good. Also 84% of patients would recommend this GP practice to someone new to the area.

Patients were happy with the appointment system. We were told that no patient would be turned away and that patients would always be fitted in.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Areas for improvement

Action the service SHOULD take to improve

Update the practice handbook so that patients are aware the services offered by the practice and the opening times.

Introduce systems to ensure that portable equipment kept in GPs is routinely checked and testing equipment be kept in date.

Outstanding practice

The practice supported its patients and their families throughout difficult times. GPs carried out bereavement checks with patient's relatives three months after the patient's death to check how the relative was coping and to see if they needed any additional support.

The practice supported vulnerable patients by delivering the Violent Patient Scheme (VPS) to vulnerable patients in Torbay and South Devon. This was a scheme that was in place to protect staff from incidents of violence and aggression and to provide access to primary medical services for patients whose violent and aggressive behaviour has caused them to be removed from the GP practice list.

Barton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**,** a GP expert and an expert by experience.

Background to Barton Surgery

Barton Surgery delivers primary care under a Primary Medical Services contract between themselves and NHS England. As part of the Devon Clinical Commissioning Group (CCG) they are responsible for a population of approximately 10000 patients.

There is a team of four GP partners (two female and two male), supported by two salaried GPs.

The practice GPs do not provide an out-of-hours service to their own patients. Patients are signposted to the local out-of-hours service when the surgery is closed at the weekends.

The practice is open six days a week and provides patient appointments between 830am and 6pm Monday to Friday. The practice also offers appointments between 6.30pm and 7pm four days a week for those people that are working. The practice is not a GP training practice at the moment but is hoping to be so again in the future.

The practice has a virtual patient representation group (PPG). This is a group that acts as a voice for patients at the practice.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

There were no previous performance issues or concerns about this practice prior to our 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.

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

Detailed findings

- 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 conducting our announced inspection of Barton Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 6 May 2015. We spoke with 12 patients, three GPs, three of the nursing team and members of the management, reception and administration team. We collected 34 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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. All of the staff we spoke with knew how to raise concerns including reporting incidents and near misses. GPs told us these were discussed at their daily coffee meetings. Monthly quality assurance meetings were held, standing items about health and safety, significant events and complaints had been discussed. This information was shared with all staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw that there were computerised records of events that had occurred. Significant events were discussed on a monthly basis as an agenda item at the management meeting. When required the practice undertook a more depth analysis of significant events at a clinical meeting. We reviewed all events recorded in the previous year. These events were investigated, discussed and action

plans were set. We saw that significant events were revisited after three months to minimise further risk. There was evidence that the practice had learned following such events and that findings were shared with staff. For example a recent prescription error had led to all staff no longer taking requests for repeat prescriptions over the telephone.

Staff including GPs, practice nurses and receptionists demonstrated the system for reporting incidents and near misses. A GP showed us their system for monitoring and managing incidents.

National patient safety alerts were disseminated by email and at the clinical meetings to staff. Staff we spoke with told us that they had received information about alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received training to an appropriate level in safeguarding children and vulnerable adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in both working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

The practice had a GP identified as lead for safeguarding vulnerable adults and children. All GPs and practice nurses had received training to an appropriate level in safeguarding children. The GP lead for safeguarding had received additional training in safeguarding and had experience of working at a senior level within the clinical commissioning group (CCG) which had benefited the practices' understanding of the safeguarding processes. All other staff had safeguarding training to an appropriate level for their role. All of the staff we spoke with were aware of who the nominated safeguarding leads were and how to raise a safeguarding concern. Safeguarding concerns had recently become a standing item on the clinical meeting agenda.

The practice had a chaperone policy. A chaperone is an impartial, trained observer who is usually a health professional to safeguard the interaction between both patient and clinician during consultations. The policy and signage stating the availability of chaperones was visible on

the waiting room notice board, consulting rooms and detailed on the practice website. All nursing staff had been trained to be a chaperone.

Medicines management

The practice held medicines on site for use in an emergency or for use during consultations such as administration of vaccinations. Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by the CCG, doctors and pharmacists which allowed nurses to administer prescription-only medicines.

GPs reviewed their prescribing practices as and when medication alerts were received. Staff told us information and changes to prescribing were communicated during meetings, or via email alerts. Staff told us they regularly

discussed and shared latest guidance on changes to medicines and prescribing practice. We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded daily to ensure the medicines were being kept at the correct temperature. Records were kept whenever any medicines were used alongside notes in patient's records.

We were shown the safety checks carried out in relation to prescriptions being issued. The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by GPs were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions. We saw prescriptions for collection were stored securely behind the reception desk. At the end of the day we were told these are locked away in a secure cabinet. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Data showed that 91% of patients who received medicines were given a structured annual medication reviews for polypharmacy in the last year. A pharmacy assistant (provided by the CCG medicines optimisation team) visited the practice on a regular basis to review the prescribing data. This included running appropriate audits, assessing the prescribing data in comparison with local and national standards and feeding back to the whole practice on a regular basis.

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurse's treatment rooms, and patient's toilets and waiting areas. All appeared visibly clean and were uncluttered. The patients we spoke with commented that the practice was clean and appeared

hygienic. Cleaners were employed by the practice and there was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. There was also a record that each task had been carried out. The practice was cleaned in line with infection control guidelines, with the cleaners routinely attending every evening.

There was an infection control policy in place. This gave full information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. The lead nurse was responsible for infection control in the practice. Infection control training was provided for all staff as part of their induction, and we saw evidence that the training was updated annually. The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated to them by the infection control lead.

There were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Hand wash and paper towels were next to each hand wash basin, and hand gel was available throughout the practice. Protective equipment such as gloves, aprons and masks were readily available. Curtains around examination couches were disposable and had been replaced within the past six months. Examination couches were washable and were all in good condition. An infection control audit had been carried out in April 2015 and no issues were identified as needing improvement.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice had last carried out a check this month, in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had a system using checklists to monitor the dates of emergency medicines and equipment which helped to ensure they were discarded and replaced as required. Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required. However, portable equipment kept in GPs bags had not been routinely checked, for example BM stix and urine

testing kits were out of date and the sphygmomanometers (used for blood pressure recording) had not been calibrated. Staff told us they had sufficient equipment at the practice.

Staffing and recruitment

Records showed that there was a low turnover of staff at the practice. We looked at four staff records, all of which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, checks of qualifications and registration with the appropriate professional body.

Criminal records checks via the Disclosure and Barring Service (DBS) had also taken place. The practice manager held a register showing when satisfactory checks had been completed, which showed that the performer list had been checked when GPs and locums were recruited. This also included the date when GPs and nurses had completed or were due to complete revalidation of their fitness to practice.

The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only nurses or healthcare assistants had this additional duty and a DBS had been obtained for all of them.

Monitoring safety and responding to risk

The practice had systems and policies in place to identify, manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the premises, equipment and medicines management. Action plans were put in place to reduce and manage any risks.

These were discussed at GP partners' and team meetings. The practice had a health and safety policy, which staff had access to. The practice manager was the health and safety representative.

We saw that staff responded to risks to patients including deteriorating health and well-being or medical emergencies. For example, on the day of the inspection a patient became acutely unwell in the waiting room. All staff knew their responsibilities and the patient was helped quickly whilst showing them dignity and kindness throughout.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The training matrix showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated defibrillator (used to attempt to restart a person's heart in an emergency). Records showed that the emergency equipment and medicines were regularly checked to ensure they were fit to use and within their expiry date. All the medicines we checked were in date and suitable to use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the day to day running of the practice. Risks identified included power failure, adverse weather, staff changes and access to the building. Actions were recorded to reduce and manage the risks.

A fire risk assessment had been completed, which included actions required to maintain fire safety. Records showed that all staff were up to date with fire training and that fire drills were carried out every six months, to ensure that people knew how to evacuate the premises, and what to do in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners, We saw minutes of practice meetings where new guidelines were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

There was a robust system in place to register patients receiving palliative care. There was a register in place in accordance with the Gold Standards Framework, which enabled staff to provide good quality care by advance care planning. A structured multi-disciplinary team palliative care meeting took place monthly between the GPs, practice manager, district nursing staff and local cancer care nursing staff. Meetings were held every month for patients at risk of admission to hospital, to discuss what could be done to reduce the risk. Each patient had a named GP and personalised care plan. The 2% considered most at risk patients were case managed, some by GPs and some by the community matron and district nurses. When patients were admitted to hospital, this was discussed by the GPs at their daily meeting. Any unplanned admission was reviewed at the monthly team meeting. GPs updated their care plans on the patient's clinical notes and care plans were transferred to the Out of Hours service via the IT system to maintain continuity of care. Systems were in place to assess risks in newly registered patients. Administrative staff arranged health care reviews for patients with learning disabilities or long term conditions. There was a system to make sure no-one was missed and if patients failed to arrive staff phoned or wrote to them to make an appointment. Patients were invited for a NHS health check which included advising them of what they were entitled to.

Information from the quality outcomes framework (QOF) showed that regular health assessments had been carried out in line with the national average. For example, the expected proportion of patients with schizophrenia or other psychoses had an agreed care plan documented in the previous 12 months. The percentage of patients who required hypnotic medication, measured within the last 12 months, was above what was expected, and recorded as an elevated risk. GPs told us that this had been noted and was being addressed. The GPs had recognised that a formal audit should be undertaken and was being planned.

Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. The system improved patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Practice nurses managed patients with clinical conditions such as diabetes or asthma with support from GPs for more complex cases. The opportunity, during regular assessments of patients over the age of 55 years, was taken to proactively check for other symptoms, for example patients were asked if they had any memory problems. Any issues were then monitored and advice given when appropriate.

There was no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were referred on need, and that age, gender, race and disability were not used as an adverse influence for decision-making. The GPs at the practice were male and female.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored. This included assessments, diagnoses, referrals to other services and the management of people with chronic or long-term conditions. This information was used to improve care. Outcomes for patients were positive, consistent and met expectations.

A GP took responsibility as the QOF lead for the practice. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The GP lead monitored the QOF closely and led on the monthly meetings which took place to discuss changes and improvements on recording the patient data.

Good

Are services effective?

(for example, treatment is effective)

The administration team were responsible for scanning letters on to patient records. This process was done the same day that the letter arrived at the practice. The transfer of test results via the clinical system took place daily and the results were electronically forwarded to the health care professional who requested the test. The GP or nurse reviewed the results in a timely manner. If they were away a buddy clinician would view the results.

Clinics had templates for staff to follow as well as a written protocol to ensure the health assessment was comprehensive. For example, when a patient with hypertension attended for their check-up, the template showed that staff checked with them about their smoking and alcohol consumption and checked their blood pressure, weight, and pulse and took a blood test.

Various audits and reviews had been completed in the last two years, and the practice was able to demonstrate the changes resulting from these. For example, a review of vaccine storage (cold chain) was completed in September 2014, resulting in various changes to ensure they remained appropriately managed and stored safely. Staff told us that the outcome of audits was communicated through the team and clinical meetings. Records showed that weekly clinical meetings were held involving the GPs and nurse practitioner. The meetings enabled the staff to discuss clinical issues and peer review each other's practice, driving improvements in care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. There were nurses with extended roles seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease. They were also able to demonstrate that they had appropriate training to fulfil these roles. Nursing staff had also received specific training to update skills, such as undertaking cervical smear tests, syringing ears and minor operations.

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).

Working with colleagues and other services

The practice had strong links locally with other service providers to aid communication and

multidisciplinary working. Staff worked with partner health and social care services to meet patients' needs. Records showed that the practice held regular multidisciplinary team (MDT) meetings to discuss complex patents, including those with end of life care needs, or in vulnerable circumstances. These meetings were attended by district nurse, social worker, school nurse and palliative care nurse.

The practice had signed up to the enhanced service to avoid unplanned admissions and to follow up patients discharged from hospital. Enhanced services are additional services provided by GPs to meet the needs of their patients. It was clear from discussions with staff that considerable work went into supporting people to remain in their own home, and ensuring they received appropriate support on discharge from hospital. For example, the GP's had direct access to a care of the elderly consultant for advice on the best treatment and whether it was appropriate for the patient to stay in the community. A care of the elderly consultant ran a rapid access clinics at the hospital that GPs were also able to refer patients to. This provided an extensive and well established intermediate care service in the community involving immediate response nursing, physiotherapy and occupational therapy support at home or in a variety of local nursing homes (where appropriate) to avoid hospital admissions.

Information sharing

A shared system was in place with the local out-of-hours provider to enable essential information about patients to be shared in a secure and timely manner. The practice used Microtest electronic system to coordinate record and manage patients' care. All staff were trained on the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference. For patients requiring emergency assessment or admission to hospital from the practice, the GPs provided a printed summary record for the patient to take with them. The

Good

Are services effective?

(for example, treatment is effective)

practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key information).

Electronic systems were also in place for making referrals. The practice had invested in a digital dictation system, which enabled clinicians to dictate and send referrals easily. The Choose and Book system enabled patients to choose which hospital they wished to be seen in, and to book their own outpatient appointments.

The practice recognised the challenge of communicating with teenagers. They had introduced a teen noticeboard, making changes to their web site and using social media to aid communication. The practice had a leaflet but the information it contained was out of date. The practice produced a newsletter for its patients to keep them updated.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment. They also said that they had the opportunity to ask questions and felt listened to. There were arrangements in place to ensure that patients consent was obtained before they received any care or treatment, and that staff acted in accordance with legal requirements. Written consent was obtained for specific interventions such as minor surgical procedures, together with a record of the possible risks and complications.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. Clinical staff understood the importance of determining if a child was Gillick competent especially when providing treatment and contraceptive advice. We saw an example where this had been applied in practice. A Gillick competent child is a child under 16 who is capable of understanding implications of the proposed treatment, including the risks and alternative options. Staff were able to demonstrate an awareness of the Mental Capacity Act 2005 and their responsibilities to act in accordance with legal requirements.

Health promotion and prevention

We saw that a wide range of health promotion information was available to patients and carers

on the practice's website, and the noticeboards in the surgery. New patients completed a form, which provided some information about their lifestyle and health and were offered an appointment for an initial health check.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the area CCG, and there was a system in place for following up patients who did not attend.

The cervical smear uptake was just below the 80% of the target rate set by the area CCG (practice value was 74%). There was a system in place for following-up patients who did not attend screening. The practice also had systems in place to identify patients who needed additional support, and were pro-active in offering help. Smoking cessation advice was given to 1027 patients and records showed that 89 patients were recorded as having stopped smoking.

All patients with a learning disability, experiencing poor mental health, over 65 years, with long standing conditions or aged 75 years and over were offered an annual health check, including a review of their medication.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The most recent data available for the practice on patient satisfaction showed very high levels of satisfaction. This included information from the national patient survey in January 2015 when 122 patients responded. High levels of satisfaction were seen in the survey responses. Access to the practice was very good and patients could see a GP quickly. 92% of patients reported that they could make an appointment or speak to someone when they requested to. All of the feedback was positive.

The evidence from all these sources showed patients were satisfied with how they were treated with compassion, dignity and respect. Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and put their needs first. Staff were described as being efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 12 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The practice had clear policies and procedures in place around confidentiality, which were being followed Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. The reception desk was situated close to some of the chairs in the waiting room and staff were behind a glass partition so this did not always provide privacy for patients discussing issues with the staff there.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and we did not hear any conversations taking place in these rooms.

Reception staff demonstrated they understood how to diffuse potentially difficult situations and confirmed they had received training on this. We saw staff put patients at ease which had a positive effect on engagement with patients that had complex mental health needs. The locality had a violent patient scheme to which the practice could refer patients. However, to meet individual needs and reduce impact for patients the practice had facilitated this scheme being run at a nearby venue. Patients were able to still be seen safely supported by external mental health workers and security staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient

survey showed 86% of practice respondents said the GP involved them in care decisions, this compared slightly higher than the local (CCG) average of 81%.

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

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

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they have sufficient time to discuss their concerns with their GP. The new appointment system enabled the patient to discuss their concern on the telephone with the GP. The GP would then determine how much time the patient needed for their appointment. For example, patients with long term conditions were allocated a longer appointment time slot depending on their need.

In a practice survey of 266 patients carried out in 2014, patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95.8% of patients considered they were treated with care and concern during their consultation with the

Good

Are services caring?

clinical team. The 12 patients we spoke with on the day of our inspection and the 34 comment cards we received were also consistent with this survey information. For example, comments highlighted that all of the staff were compassionate, caring and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice had links with a carer support worker. Appointments were available each month for carers to have a health check. The practice ran a carers group, which provided access to advice and information and was next due in January 2016. The Citizens Advice Bureau have started an initiative which involves a caseworker working in partnership with primary health teams at Barton surgery providing home visits to carers, disabled adults, families with children with disabilities and the frail elderly on complex non-medical issues. The aim of the post is to develop a linked, co-ordinated and holistic approach to support the carer (and cared for) to live well within their community through enabling better access to specialised advice, information, knowledge, skills, relationships and resources.

GPs carried out bereavement checks with patients relatives after death and then again at three months to check how the relative was coping and if they needed any additional support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw records of significant events and complaints which had been shared with the local CCG.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The group was made up of 220 representatives from a sample of patients who received care and treatment from the practice. This included a young mother, patients from the working population, patients with long term conditions and patients over 75 years. The practice had worked with the group when making decisions about the service that may have an impact on patients. For example when the practice changed how patients would make their appointments.

Tackling inequity and promoting equality

The practice held a contract to provide GP services to patients who had previously displayed unacceptable behaviour to healthcare workers. This was an enhanced service and included patients that were previously registered at other local practices. The scheme included patients of whom had been excluded from other local practices, due to displaying behaviour to healthcare workers that was unacceptable and had involved the police.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and promoted this in their work.

The practice had level access from the car park to the front door. Inside the GP consultation rooms and the treatment rooms were located on the first floor, a passenger lift was available.

The premises were modern and purpose built. The seats in the waiting area were differing heights and size. There was variation for diversity in physical health and all chairs had arms on them to aid sitting or rising. Audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available. The reception desk was of one height but was not suitable for those people that used a wheelchair. Receptionists said they stood up if someone came in a wheelchair so they could talk to them.

The practice had access to telephone translation services for patients whose first language was not English.

Access to the service

The practice was open six days a week and provided patient appointments between 8.30am and 6pm Monday to Friday. The practice also offered appointments between 630pm and 7.00pm four days a week and was open every Saturday morning between 9.00-12.00pm.

There was an easy to use appointment system, which supported patient choice and enabled the patients to access the right care at the right time. The practice implemented a new appointment system in June 2013. Each patient that rang for an appointment told the receptionist a brief description of the presenting problem and how urgent it was if they chose to do so. The message was passed through to a GP who then prioritised the call. This enabled them to assess whether the person needed to either discuss the problem on the phone, receive a home visit or required an appointment in the practice. The practice manager told us this had enabled the practice to allocate an appropriate time length for appointments, deal with patient problems over the phone and see patients more promptly for urgent needs.

Patients who requested an appointment on the same day were guaranteed to receive an appropriate response via an appointment or call back. Patients were also able to book appointment by telephone or the practice online appointment service. The practice opening hours were clearly displayed in the practice and on their website. If patients required GP assistance out of practice hours then details of who to contact were clearly displayed in the practice, on their website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients told us they were happy with the appointment system. They made and contacted the practice easily for an appointment, were given an appointment when needed and often saw their doctor of choice. Patients said they never had to wait long to be seen by the GP and were informed if there was a delay. On the day of our inspection, patients had their appointment at the correct time.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The practice website and booklet contained a section on how to make a complaint. There were also notices in the waiting room explaining the action to take in the event of a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 34 complaints received in the last year and found that all had been dealt with in a timely way and resolved to satisfaction at a local level with no complaints being referred to the Parliamentary and Health Service Ombudsman (PHSO). The practice reviewed complaints to detect themes or trends and lessons learned from individual complaints had been acted on. For example six appointments were made available that could be booked two weeks in advance following several complaints about the new appointment system.

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. On the day of our inspection we spoke with a number of patients and staff who all spoke

very positively about how these aims were being upheld and modified to meet the needs of patients. We saw that staff demonstrated a positive approach to the practice aims and comments from patients we received aligned with this. We met two representatives of the patient participation group, as well as receiving comment cards from 32 patients. All the comments received were positive about the service provided.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice.

We saw that leadership at the practice was strong and decisive. Staff had taken ownership of lead roles and could demonstrate they had improved outcomes for patients over time. There were leads for safeguarding, infection control and clinical speciality areas. All of the staff we spoke with were clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was consistently performing in line or better than expected with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. For example, prescribing of medicines was closely monitored to ensure decisions about prescribing were evidence based and value for money.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at one completed audit which demonstrated improvements for patients who were prescribed blood thinning medication. The audit looked at each patient and showed improvements had been made in ensuring every patient had their blood tested at the appropriate intervals. This showed that patient safety had been improved. The audit had been shared with all staff for discussion.

Arrangements were in place to ensure staff were clear about their responsibilities and were familiar with practice procedures. An annual practice meeting schedule was in place which covered administration meetings, clinical meetings and business meetings. The meetings supported staff and ensured they were kept up to date with changes to practice systems. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively.

Every morning a clinical meeting was held which GPs and nurses told us they found very valuable in discussing day to day clinical issues and obtaining support from colleagues.

The practice operated a buddy system for GPs and nurses to ensure suitable cover was provided when their buddy colleague was on leave. This included checking correspondence and test results. Unchecked test results were highlighted on the screen and could only be closed when a GP had reviewed the result and recorded the action to be taken. The practice regularly reviewed its policies and procedures and implemented changes as a result of learning from serious events.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice manager was responsible for human resource policies and procedures.

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

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. We looked at the results of the annual national GP survey for 2014, which 122 patients provided responses for. High levels of satisfaction were seen in the responses to the national GP survey. Access to the practice was very good and patients could see a GP quickly. 92% of patients reported that the last time they got an appointment that it was convenient to them, this compares higher than the local CCG average of 72%.

Are services well-led?

Good

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

The practice had an active virtual patient participation group (PPG) which had a membership of approximately 220 patients. The virtual PPG included representatives from various population groups; patients with long term and mental health conditions, older and disabled people, mothers and young people. The group communicated with each other via email or by meeting up when needed. We met two representatives at the inspection and they told us the partners at the practice listened and were keen to make improvements for patients.

The practice manager showed us the analysis of the last patient survey. The results and actions agreed from these surveys were available on the practice website. The practice had acted on comments, for example in introducing a new appointment system.

There was a low turnover of staff at the practice. Staff said they felt their views were valued and they felt listened to. The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. There was an open culture and staff told us they did not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Minutes of all the meetings we reviewed showed there was a clear process of reporting progress back to staff and linking issues across the whole team.

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

Management lead through learning and improvement

The practice had systems in place to enable learning and improve performance. The practice involved patients, staff and other services/professionals when they considered how to improve the service provided. The practice had made a number of significant changes recently. This included implementing a new appointment system which guaranteed patients would see their GP the same day if needed.

The staff we spoke with told us that they had been supported to develop skills and knowledge appropriate to their role. The nursing staff held a diverse range of additional qualifications and skills which enabled them to play a vital part in managing patients' health needs. An example was one nurse who was trained to undertake minor operations.

The practice was a GP training practice until 2013 (a training practice provides placements for pre-qualification medical students and GPs in training). However, it was currently not taking students because of the increased workload and new appointment system being in its infancy. We were told the practice hoped to become a training practice again in the future.