The Oswald Road Medical Centre

Quality Report

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Date of inspection visit: 24 February 2015
Date of publication: 25/06/2015

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 carried out an announced comprehensive inspection at The Oswald Road Medical Centre on 24 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services that meet the needs of the population it served.

Our key findings were as follows:

- Patients who used the service were kept safe and protected from avoidable harm. The building was well maintained and clean.
- All the patients we spoke with were positive about the care and treatment they received. The CQC comment cards and results of patient surveys showed that patients were consistently pleased with the service they received.
- There was good collaborative working between the practice and other health and social care agencies that ensured patients received the best outcomes. Clinical decisions followed best practice guidelines.
- The practice met with the local Clinical Commissioning Group (CCG) to discuss service performance and improvement issues.
- There were good governance and risk management measures in place. The leadership team were visible and staff we spoke with said they found them very approachable.

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

Importantly the provider should:

- Ensure monitoring checks for health and safety and the environment are documented.
- Review the appraisal process to ensure that documented records are available in staff files.
- Implement a process to record informal concerns to identify any patterns or trends that might be emerging and actions to prevent recurrence.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above the local CCG average for all clinical indicators. Care and treatment was being considered in line with current guidelines and legislation. This included assessing capacity and promoting good health. Patient's needs were consistently met and referrals to other services were made in a timely manner. Staff worked with multidisciplinary teams. The practice undertook clinical audit and monitored the performance of staff. Staff had received training appropriate to their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well for several aspects of care. Feedback from patients about their care and treatment was positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and the practice responded to complaints and comments appropriately.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The leadership team was visible and it had a clear vision and purpose. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Governance arrangements were in place and there were systems for identifying and managing risks. Staff were committed to maintaining and improving standards of care. Key staff were identified as leads for different areas in the practice and they encouraged good working relationships amongst the practice staff. Staff were well supported by the GPs and practice manager.

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. The practice was knowledgeable about the number and health needs of older patients using the service and actively reviewed the care and treatment needs of these patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients over the age of 75 had a named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had a good understanding of the care and treatment needs of these patients. The practice closely monitored the needs of this patient group. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. There was a recall programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. We heard from patients that staff invited them for routine checks and reviews. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered comprehensive vaccination programmes which were managed effectively. Immunisation rates were relatively high for all standard childhood immunisations. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured children who were unwell could be seen quickly by the GP or nurse.

Summary of findings

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 this population group 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 provided a range of options for patients to consult with the GP and nurse. Late night clinics were available two evenings a week. The practice was proactive in offering online services. Useful information was available in the practice and on the website as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. The practice offered these patients longer appointments. We found that all of the staff had a very good understanding of what services were available within their catchment area, such as supported living services, care homes and families with carer responsibilities.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. They had access to the practices' policy and procedures and discussed vulnerable patients at the clinical meetings.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems including dementia. The register supported clinical staff to offer patients an annual appointment for a health check and a medicines review. Data for 2013/2014 showed 78.6% of patients diagnosed with dementia had received a face to face review in the previous 12 months; this was similar to the local CCG average. Documented care plans had also been completed for 89.5% of patients with other mental health problems such as schizophrenia, bipolar affective disorder and other psychoses; this was above the local CCG average.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The mental health counsellor provided two sessions a week at the practice to support this population group. Information was available for patients on counselling services and support groups.

Summary of findings

What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from 33 patients which were very positive about the care and treatment they received from the practice. Patients said staff were polite and helpful and always treated them with dignity and respect. Patients described the service as excellent and said the nurses and GPs were always friendly and caring.

We spoke with eight patients during the inspection and they also confirmed that they had received very good care and attention and they felt that all the staff treated them with dignity and respect. Feedback from patients showed that staff involved them in the planning of their care and were good at listening and explaining things to them. They felt the doctors and nurses were knowledgeable about their treatment needs.

We looked at the results of the national GP survey for 2014 where 112 patients had responded. Results showed that patients were generally positive about the service they received and the practice performed at or above the weighted CCG (regional) average in a number of areas. For example:

- 86% of respondents would recommend this surgery to someone new to the area - CCG local average: 77%
- 77% of patients said it was easy to get through to the practice on the phone - CCG local average: 70%
- 96% of respondents describe their overall experience of this surgery as good – CCG local average: 84**%**
- 96% of respondents describe their experience of making an appointment as good – CCG local average: 72%
- 97% of respondents find receptionists at this surgery helpful – CCG average: 87%

We looked at the results of the Practice's survey for 2014 which 120 patients had completed and saw they were also very positive about the services delivered.

These results were consistent with our findings on the day of the inspection.

We found that the practice valued the views of patients and saw that following feedback from surveys and from patients attending the practice; changes were made to improve the service.

Areas for improvement

Action the service SHOULD take to improve

- Ensure monitoring checks for health and safety and the environment are documented.
- Review the appraisal process to ensure that documented records are available in staff files.
- Implement a process to record informal concerns to identify any patterns or trends that might be emerging and actions to prevent recurrence.

The Oswald Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector and included a second CQC inspector, a GP Specialist Advisor and a Practice Manager Specialist Advisor.

Background to The Oswald Road Medical Centre

The Oswald Road Medical Centre is situated in Scunthorpe and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the Scunthorpe area. The practice provides services to 4086 patients of all ages. There is a slightly higher percentage of the practice population in the 65 to 84 years and over age group than the England average and the over 85 age group is the same. There is a slightly higher percentage in the under 18 age group than the England average. The overall practice deprivation score is higher than the England average, the practice is 31.1 and the England average is 23.6.

The practice has two GP partners, one male and one female. There are two practice nurses and two phlebotomists. There are two practice managers who job share and one assistant practice manager. The practice has a team of secretarial, reception, administrative and support staff.

The practice provided services to their patients through a General Medical Services contract.

The practice has opted out of providing out of hours services (OOHs) for their patients. When the practice is closed patients use the 111 service. Information for patients requiring urgent medical attention out of hours is available in the waiting area, in the practice information leaflets and on the practice website.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out an announced inspection 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:

Detailed findings

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 24 February 2015.

During our visit we spoke with a range of staff including two GPs, the practice nurses, the practice managers and assistant practice manager, a receptionist and the secretary. We also spoke with the palliative care nurse who was visiting the practice. We spoke with eight patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone. We also reviewed 33 CQC comment cards where patients were able to share their views and experiences of the service.

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 an incident had been reported where a referral letter had been sent to the wrong department at the hospital.

We reviewed incident reports and minutes of meetings where incidents that had occurred over the past two years were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. The practice discussed incidents at the practice meetings which occurred monthly. A dedicated meeting would be held if a significant event occurred. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence of actions taken following incidents. For example the practice had changed their procedure when a referral letter had been sent to the wrong hospital department. Staff dealing with referrals were now given protected time for making referrals and they were done in a separate room and not on the reception desk.

National patient safety alerts were disseminated by e mail to practice staff who then took any action required. Staff we spoke with were able to give examples of recent alerts that were relevant to their role. They also told us that where necessary, alerts were discussed at staff meetings to ensure all staff were aware of any action that needed to be considered.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that staff had received relevant role specific training on safeguarding. 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 and document safeguarding concerns, and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained to level three in children's safeguarding and could demonstrate they had the necessary knowledge to enable them to fulfil this role. Staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The GP explained how they worked with the health visiting and social services teams when they had safeguarding concerns.

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 or patients with dementia. If a patient was subject to a child protection plan this was highlighted on their record.

GPs were appropriately using the required codes on the electronic records system to ensure risks to children and young people who were on looked after or child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and explained how they would liaise with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or where they missed appointments frequently. These were brought to the GPs

attention, who then worked with other health professionals such as health visitors, midwives and district nurses. We saw minutes of meetings where vulnerable patients were discussed.

There was a chaperone policy and information telling patients that they could ask for a chaperone was visible in the waiting room and 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). Nursing and reception staff acted as chaperones and understood their responsibilities, including where to stand to be able to observe the examination. All staff had received chaperone training. Patients confirmed they had been offered chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear procedure for ensuring that refrigerated medicines were kept at the required temperatures and the action to take in the event of a potential failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that the nurse had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept secure at all times.

The practice was supported by a pharmacy advisor from the local commissioning support unit. They worked with the practice to review and audit prescribing activity to ensure action was taken to address any prescribing concerns. They told us that the practice was very responsive and keen to participate in reviewing their prescribing patterns. We saw that medicine and prescribing reviews had been completed and action taken following medication alerts so prescribing was in line with national best practice.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for IPC who was responsible for ensuring good practice was followed. External advice and support was available for practice staff and the IPC lead attended the local IPC link nurse meetings. All staff received induction training about infection control specific to their role and received regular updates. Staff confirmed they had completed training in infection prevention and control.

The practice monitored the standards of cleaning in the practice regularly so any areas for improvement could be identified and actioned. Audits had been carried out in the last two years and any improvements identified for action were completed.

Staff told us there was always sufficient personal protective equipment (PPE) available for them to use, including masks, disposable gloves and aprons. Staff were able to describe how they would use these to comply with the practice's infection control procedures. For example staff told us they wore disposable gloves when handling specimens such as blood or urine. Hand wash, disposable towels and hand gel dispensers were readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff told us that equipment used for procedures such as cervical smear tests and for minor surgery were disposable. Staff were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Good

Are services safe?

We saw evidence that staff had their immunisation status for Hepatitis B checked which minimised the risk of staff transmitting infection to patients. Staff told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

The practice had systems for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all medical equipment was tested and maintained regularly and we saw records that confirmed this. For example weighing scales and blood pressure machines had all been checked within the last 12 months. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a system in place for all the different staffing groups to ensure that enough staff were on duty. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Feedback from patients we spoke with and on the CQC comment cards and surveys confirmed they could get an appointment to see a GP or nurse when they needed to.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building and the environment. These checks were not routinely documented. The practice had a health and safety policy which identified who the health and safety lead was and how health and safety would be managed and risks controlled. Health and safety information was displayed for staff to see.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with respiratory problems whose health had deteriorated suddenly and how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency airway equipment and oxygen was available. Emergency medicines were available; these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check the emergency equipment was working and that emergency medicines were within their expiry date and suitable for use. Records confirmed that equipment was checked regularly to ensure it was working and that medicines had not expired. All the medicines we checked were in date and fit for use.

The practice had access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). However this was shared with a dental practice across the road. The practice was in the process of re-assessing the risk of not having a de-fibrillator on site.

Good

Are services safe?

Records showed that all staff had received training in basic life support and the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. They all knew the location of the emergency equipment and medicines.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned staff sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received fire training and fire drills had been carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance was readily accessible in all the clinical and consulting rooms. We discussed with the practice managers, GPs and nurses how NICE guidance was received into the practice. They told us that this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed. Implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

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. We found from our discussions with the GPs and the nurses that staff completed thorough assessments of patients' needs in line with national and local guidelines, and these were reviewed when appropriate.

The GPs told us they led the clinical team and supported the practice nurses to provide care to all patient groups. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The nurses told us they continually reviewed and discussed new best practice guidelines, for example for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. We saw that after these patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients, for example for patients with suspected cancers who were referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice played a role in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice showed us five clinical audits that had been completed. Following each clinical audit, changes to treatment or care were made where needed. For example, in February 2014 the practice had carried out an audit of contraceptive implant insertions that were done during 2013. The purpose of the audit was to check consent was being obtained, complication rates, the percentage of patients who had side effects and how many implants were removed within one year of insertion. Targets were set for each of these areas. The audit demonstrated that the practice was meeting the targets and no actions were required. A re-audit was planned for February 2015 to confirm that standards were being maintained.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme

Good

Are services effective?

(for example, treatment is effective)

financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). QOF data for 2013/2014 showed the practice was performing above the CCG average for all the clinical indicators including asthma and chronic obstructive pulmonary disease (lung disease). The practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, peer supervision 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. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should be involved in the audit process.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes, and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example rates for emergency admissions to hospital.

The practice was involved in the 'Productive General Practice' programme, which encouraged staff to openly review the service and determine where they could improve. The staff we spoke with discussed how this programme assisted them to constantly review and improve their practice and the overall service being provided.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the training matrix and saw staff were up to date with attending mandatory courses such as basic life support, fire safety and safeguarding children and adults. The training matrix outlined what training each member of staff had attended, if any refresher training was required and at what intervals this should occur.

All GPs were up to date with their yearly continuing professional development requirements and had either 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff told us the appraisal was an opportunity to discuss their performance, any training required and any concerns or issues they had. The GPs did the appraisals for all staff in the practice and kept the records. We were not able to view any appraisal documents during the inspection.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The nurses had completed training in areas specific to their role, for example chronic obstructive pulmonary disease and cervical smears. The staff we spoke with confirmed they had access to a range of training that would help them function in their role.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff described how they had shadowed other staff in the practice during their induction period so they became familiar with how the practice worked. Staff told us that role specific induction, for example immunisation training for nurses was available for new staff.

Good

Are services effective?

(for example, treatment is effective)

There was a process in place to manage poor performance of staff members.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood tests, X ray results, letters from out-of-hours GP and 111services and local hospitals, (including discharge summaries) electronically and by post.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who requested the test or investigation was responsible for reviewing their own results and if they were on holiday the results were sent to the 'duty doctor' for that day. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

There was a system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care which helped to ensure that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

The practice held multidisciplinary team (MDT) meetings every two months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, health visitors and palliative care nurses. Decisions about care planning were documented in the patients' care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We spoke with the community matron who told us that the practice staff worked well with other MDT members and communication and collaborative working was good.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. However the practice was not using the system to its' full potential. For example, some staff wrote messages about repeat prescription requests on pieces of paper which were attached to the prescription. There was a risk that messages could become detached and no audit trail was available. The practice had identified this as a risk and was working to improve its' use of the electronic system to send messages to staff when actions were required. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Patients could also register for access to an electronic system which gave them a summary of their medical history, medication, allergies and access to test results and letters.

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 GPs and nurses had completed mental capacity awareness training.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if

Good

Are services effective?

(for example, treatment is effective)

changes in clinical circumstances dictated it). 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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and then documented in the electronic patient record. The consent form outlined the relevant risks, benefits and complications of the procedure and the clinician and patient both signed the form. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

Health promotion and prevention

It was practice policy for all new patients registering with the practice to complete a health questionnaire to assess their past medical and social histories, care needs and assessment of risk. Patients were then offered a new patient medical with the practice nurse. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering alcohol screening to newly registered patients. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were followed up if they had risk factors for disease identified at the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. The number of patients with mental health problems who had a comprehensive care plan documented in their record which had been agreed between individuals, their family and/or carers as appropriate was 89.5%; this was above the CCG average.

QOF data for 2013/2014 showed the practice had identified the smoking status of 92.1% of patients over the age of 15 and 90.8% of these patients had been offered support and treatment within the preceding 12 twelve months. Also the practice had recorded the smoking status of 98.3% of patients with conditions such as heart disease, stroke**,** hypertension, diabetes, respiratory problems, asthma and mental health conditions. Ninety eight per cent had a record of an offer of support and treatment recorded in their records within the preceding 12 months. Performance for smoking cessation support for these patients was above the local CCG average. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 86%, which was above the local CCG average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The nurses were responsible for following up patients who did not attend for screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Immunisation rates for children were relatively high. Again there was a clear policy for following up non-attenders by the practice. Flu immunisations rates for patients with diabetes were 84.3% and for respiratory disease 85.8%, both were above the local CCG average.

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in 2014 which had 112 respondents and a survey undertaken by the practice's patient participation group (PPG) which had 100 responses. The evidence from these sources showed patients were satisfied with how they were treated. This was with compassion, dignity and respect. Data from the national patient survey showed 88% of respondents stated that the last GP they saw or spoke to was good at treating them with care and concern and 95% said the GP was good at listening to them. The local CCG average for these two areas was 85% and 88% respectively. The satisfaction rate for the nurses for both these areas was 94% and 97% and the local CCG average was 90% and 92% respectively.

Patients were also positive about their overall experience of the practice with 96% saying their overall experience of the surgery was good and 86% saying they would recommend the surgery to someone new to the area. The local CCG average was 84% and 77% respectively.

We received 33 completed CQC comment cards and spoke with eight patients during the inspection. Feedback was very positive about the service experienced. Patients said staff were polite, friendly and helpful and always treated them with compassion, dignity and respect.

Staff were familiar with the steps they needed to take to protect patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception area was in the waiting room and had a glass window which was closed when staff were talking on the telephone. This reduced the risk that confidential conversations would be overheard. We observed no confidential information being discussed from the waiting area. There was a room available if patients wished to discuss a matter with the reception staff in private, and there was a notice informing patients that this was available.

We observed reception staff treating patients with respect and being extremely tactful when dealing with requests. Data from the national patient survey 2014 showed 97% of respondents found the reception staff helpful, the local CCG average was 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

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 85% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. The local CCG average was 80% and 84% respectively. The satisfaction rate for the nurses for these two areas was 92% and 94% respectively and the local CCG average was 83% and 89%.

Feedback from patients also indicated that 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.

Staff told us that translation services were available for patients who did not have English as a first language. There were notices in the reception area informing patients about the translation service. Google translate was available on the practice website.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Feedback from the comment cards and the patients we spoke with on the day said they had received help to access support services to

Good

Are services caring?

help them manage their treatment and care when it had been needed. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices and leaflets in the waiting room and the practice website also told people how to access a number of support groups and organisations. This included MIND for help with mental health issues and services for support following bereavement. The practice's computer system alerted GPs and nurses if a patient was a carer. The nurses told us that they would signpost patients who were carers to support groups and services that could help them. Carer's packs were available in the waiting areas and the practice sent a pack to any patients identified as a carer.

Patients receiving end of life and palliative care were well supported by the GPs and nurses in the practice. The practice sent a bereavement card to people whose relatives had died and arranged an appointment at the practice or to visit them at home if requested. Information on support services was available for patients and carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, when the practice carried out alterations to the building they took account of the needs of people with hearing and sight impairments. The new calling in system displayed patient's names and the room number they needed to go to so anyone with a hearing impairment could see when they were being called in. The system also announced the patient's name and the room number so anyone with a visual impairment could hear when they were being called in.

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. The practice identified a need for their older housebound population to receive equity of care. Each older person was being reviewed and if required a care plan was developed and agreed with the GP. This was part of the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme" which the practice was participating in. This was a strategy introduced in 2014 where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. All patients who had had an unplanned hospital admission were now contacted by the nurse after discharge to provide support and arrange any services or help that the patient required.

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, in the 2013 survey patients had commented that it was sometimes difficult to get through on the phone to order repeat prescriptions. The practice had promoted the use of the on line prescription ordering service through their website, on the information screen in the waiting room and on the counterfoil of the prescriptions. The uptake of on line prescription ordering had increased during 2014.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example they gave longer appointment times for patients with learning disabilities. The majority of the practice population were English speaking but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. All patients could be involved in decisions about their care.

The practice was accessible to patients with mobility difficulties. Consulting and treatment rooms were all on the ground floor. The consulting rooms were accessible for patients with mobility difficulties and there was also access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. A hearing loop was installed to assist patients who had hearing difficulties.

Staff told us they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen. They would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

Access to the service

Patients could make appointments in different ways, either by telephone or face to face and on line booking via the practice website would be available from March 2015. The surgery was open from 8.00am to 6.30pm Monday to Friday and offered late night appointments until 7.30pm two evenings a week. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. The GPs, nurses and receptionists all told us that if patients needed to be seen urgently they were given an appointment the same day. Patients could register to receive text reminders for their appointments.

Comprehensive information for patients about appointments was available in the patient information leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how

Good

Are services responsive to people's needs?

(for example, to feedback?)

they would be able to make appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring, depending on the circumstances.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor or nurse on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Data from the national patient survey showed 96% of patients described their experience of making an appointment as good; the local CCG average was 72%. Reception staff told us they felt the system worked well and they felt they could always offer patients an appointment.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. Home visits were available for housebound patients and for those too ill to attend the surgery. Appointments were available outside of school hours for children and young people.

The practice also provided telephone consultation advice. Patients who worked during the day or were unable to get to the practice had a choice of how they made their appointment and how and when they wanted to see the GP or nurse.

Patients could order repeat prescriptions by telephone, by post, in person or on line. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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. Information on how to make a complaint was on the practice website, in the complaints information leaflet and displayed in the waiting room. We saw that the complaints policy had details of who patients should contact and the timescales they would receive a response by. The timescales in the policy were different to the timescales in the leaflet.

Patients we spoke with told us they would speak with a member of staff if they were not happy with the service. None of the patients we spoke with had ever needed to make a complaint about the practice.

Staff were aware of how to deal with concerns raised by patients and described how they would support someone who was not happy with the service.

The practice had not received any formal complaints for two years. Staff told us about informal concerns that patients had raised and how they had dealt with them. No records were kept of these concerns so the practice was unable to identify any patterns or trends that might be emerging.

We saw that the practice had received a number of cards and letters thanking staff for their kindness, support and care.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality healthcare and promote good outcomes for patients. We spoke with nine members of staff and they all told us that the practice strived to deliver a caring, high quality service that provided positive outcomes for their patients. The vision was not visible in the waiting area or on the practice website.

The doctors, nurses and all other staff were dedicated to offering a professional service and helping to keep patients up to date with news and information about the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at 11 of these policies and procedures and saw they had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) and data from the CCG to measure its performance. The QOF data for this practice showed it was performing above the local CCG average in all of the indicators. We saw that QOF and CCG data was discussed at the team meetings and action agreed where necessary to maintain or improve outcomes.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

We saw evidence that they used data from various sources, including incidents, complaints and audits to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG.

The practice had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example fire safety. The practice monitored risks on a regular basis to identify any areas that needed addressing, however the findings were not documented.

The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the practice had undertaken audits for the prescribing of a medicine taken for nausea and vomiting. Guidance stated that the dosage and duration of use should be reduced in patients with cardiac problems. The practice had reviewed all the patients taking the medicine and altered prescriptions where necessary. This ensured they were using the medicine in line with clinical guidelines.

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

Leadership, openness and transparency

We saw from minutes that practice meetings for all staff were held regularly, at least monthly and these were used for staff to raise concerns, to share information and to discuss lessons learned from incidents. 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 managers were responsible for human resource procedures. We saw that there was an induction procedure in place and there were policies or procedures for disciplinary issues and bullying and harassment. We saw that mechanisms were in place to support staff and promote their positive wellbeing. The staff we spoke with told us they were well supported and the staff worked well as a team.

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

Are services well-led?

Good

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

The practice had gathered feedback from patients through the Patient Participation Group (PPG), surveys and complaints received.

The practice had an established PPG which met quarterly. There was information on the practice website and in the waiting room encouraging patients to become involved in the PPG. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. We saw changes had been made following feedback from the PPG, for example the group had suggested using the information screen in the waiting room to make patients aware they could order prescriptions on line. This had increased the number of prescriptions ordered on line.

We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

There was a suggestion box in the reception area in the surgery and patients could also provide feedback through the practice website. We found that the practice was very open to feedback from patients. The practice had also commenced the Friends and Family feedback project.

The practice had undertaken a staff survey in 2014 and also gathered feedback 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. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us they discussed their personal development plan during their appraisal, no records were available for us to view. Staff told us that the practice was very supportive of training, for example one nurse told us they had done the cervical smear course.

The practice had completed reviews of significant events and other incidents and shared the learning with staff at meetings to ensure the practice improved outcomes for patients. For example, an error occurred when a prescription for insulin had been changed incorrectly because two patients had similar names. Following this the process was amended so at least two pieces of patient information was checked before prescriptions were changed.