Brook Medical Practice

Quality Report

Ecton Brook Road
Ecton Brook
Northampton
Northamptonshire
NN3 5EN
Tel: 01604 401185
Website: www.thebrookmedicalcentre.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brook Medical Centre.

The practice achieved an overall rating of good. This was based on our rating of all of the five domains. Each of the six population groups we looked at achieved the same good rating.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported by management.

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

Importantly the provider should:

- Review the vinyl flooring in the treatment room and ensure it meets current infection control requirements
- Assess the carpeted areas in patient consultation rooms so the risk of fluid spillage is minimised
- Ensure recruitment arrangements include all necessary employment checks for all staff
- Ensure systems are in place to confirm medicines are being checked and managed appropriately
- Review and formalise appraisal arrangements for all staff

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. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. 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. The practice operated a triage system for appointments, 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 easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and plan. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance

Summary of findings

meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, and attended staff meetings and events.	

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Patients over 75 had a named GP to promote continuity of care. The practice premises were accessible to those with limited mobility. The practice offered proactive, personalised care to meet the needs of the older people in its population. It 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours.

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 a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 92% of people experiencing poor mental health had received an agreed care plan in the preceding 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with five patients during our inspection. They were from different backgrounds and with different health needs.

Patients 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.

We reviewed 18 CQC comment cards which had been completed by patients prior to our inspection.

All were complimentary about the practice, staff who worked there and the quality of service and care provided. Patients commented that the staff who worked there were very caring and helpful. They had been treated with respect and dignity at all times and they found the premises to be clean and tidy. Comments in three cards noted patients' frustration at the long process of triage and remarked that the wait for a call back from the GP or the nurse was long.

In the national GP patient survey patients had responded less favourably to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the survey showed 50% of practice respondents said the GP involved them in care decisions and 57% felt the GP was good at explaining treatment and results. Both these results were below the local CCG average.

Areas for improvement

Action the service SHOULD take to improve

- Review the vinyl flooring in the treatment room and ensure it meets current infection control requirements
- Assess the carpeted areas in patient consultation rooms so the risk of fluid spillage is minimised
- Ensure recruitment arrangements include all necessary employment checks for all staff
- Ensure systems are in place to confirm medicines are being checked and managed appropriately
- Review and formalise appraisal arrangements for all staff

Brook Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team on 19 March 2015 was led by a CQC Lead Inspector. The team included a GP and a practice manager acting as specialist advisers.

Background to Brook Medical Practice

Brook Medical Centre situated in Ecton Brook provide a range of primary medical services to patients who live in Ecton Brook and surrounding areas near the town centre of Northampton in Northamptonshire. The practice has a registered population of approximately 6619 patients. The practice population is predominantly white British but also serves patients from the ethnic minority groups.

Clinical staff at this practice includes three GP partners, two nurse prescribers and two qualified nurses. Management, administration and reception staff support the practice. Community nurses, health visitors and a midwife from the local NHS trusts also provide a service at this practice.

Out of hours care when the surgery is closed is through the NHS 111 service.

Why we carried out this inspection

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

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

This provider had not been inspected before and that was why we included them.

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

We began the inspection of this practice under the new comprehensive inspection programme on 9 October 2014, but that inspection was inconclusive. This inspection on 19 March 2015 was to conclude the pervious inspection and to make judgements on the findings.

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. These groups are:

Older people

Detailed findings

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 hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 March 2015.

During our visit we spoke with a range of staff including GPs, reception staff, nurses, the registered manager and other practice staff and spoke with patients who used the service. We observed how staff dealt with patients and carers who attended the practice during our inspection. We reviewed comment cards where patients and members of the public shared 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 clinical staff had expressed concerns about the carer's knowledge of patient's needs when accompanying them for their consultation. The practice had worked with the people or carers concerned to improve this.

We reviewed safety records and incident reports for the past year. This showed the practice had managed these consistently over time. Practice staff told us that they reviewed safety incidents at least monthly and identified learning points. The practice manager told us that previously records of discussions at these meetings had not been made consistently but had been recommenced since October 2014 and we saw evidence of this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff reported incidents to the practice manager who showed us the system used to manage and monitor incidents.

There were records of significant events that had occurred during the last year and we were able to review these. Significant events were reviewed at least monthly and we saw evidence of this. During this meeting they reviewed actions and identified learning points from past significant events both clinical and non clinical. Records showed that appropriate learning and improvements had taken place, and that the findings had been communicated. For example clinical staff had reported an incident where a patient had attended for a procedure without undergoing the pre procedural routine tests. The practice had taken action to ensure patients were made aware of this requirement.

National patient safety alerts were received by the practice manager and practice nurse and cascaded to the appropriate staff. Clinical staff told us that they received these and took action as required.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details and referral pathways were clearly visible in each consultation room.

The practice had a GP lead in safeguarding vulnerable adults and another GP lead in safeguarding children. Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues for example the management of 'looked after children' who are children that need specific protection in the community.

We saw that the practice team had regular contacts with the health visitor, and other clinical and relevant staff to discuss ongoing safeguarding issues and agree plans for keeping patients safe. The safeguarding lead or a nominated representative attended child protection case conferences and reviews where appropriate.

Notices were in the practice to inform patients that a chaperone was available if required. Staff we spoke with confirmed that chaperoning was carried out by clinical staff only.

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 protocol for ensuring that medicines were kept at the

required temperatures, which described the action to take in the event of a potential failure. Electronic temperature monitoring of medicine refrigerators was introduced in October 2014 and these were reviewed daily by the practice manager and we saw records of this.

Medicines were checked every other month to ensure they were within their expiry date and suitable for use. We however did not see documentary evidence to support these checks. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

A review of prescribing data, for example, patterns of antibiotic and hypnotics prescribing within the practice showed that the practice performance was in line with national trends.

Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Individual blank prescription sheets were tracked through the practice and kept securely at all times and were handled in accordance with national guidance.

We reviewed the repeat prescriptions system in use at the practice. Repeat prescriptions requests could be made by patients online or by written request at the practice. There was a repeat prescription review process in place, which meant patients that used medicines over longer periods were required to attend for periodic reviews with their GP before they continued taking the medicine to make sure it was still appropriate treatment for them.

Cleanliness and infection control

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

The practice had a clinical lead nurse for infection control who had undertaken training in infection control. All staff received induction training about infection control specific to their role and had received updates and we saw records that confirmed this.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury which was undated but gave the correct information and staff knew the procedure to follow in the event of an injury. The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in consultation and treatment rooms. We saw evidence that the lead had carried out an audit and a work plan was currently being developed in conjunction with the practice manager.

The practice with the exception of the treatment room used by the practice nurse was carpeted throughout. The treatment room flooring was of the vinyl type. However we noted that the vinyl flooring did not extend up the walls for a short distance to provide an easy-to-clean coving. The practice manager told us that the flooring was laid some time ago and would review this in the light of current advice. In patient consultation rooms we noticed that the hand wash sink area could be occasionally used to test urine. However we did not see a risk assessment to ensure these areas were protected from spillage.

There were effective arrangements for the regular collection of clinical waste and the disposal of used sharp instruments. The practice manager told us that there were no external storage facilities for clinical waste and sharps but told us that these were not needed as the collection company collected the waste and sharps every week.

The practice had a legionella and water safety risk assessment carried out in 2011. A subsequent certificate of legionella water testing in January 2014 had identified no bacteria in the water system.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and

displayed stickers indicating the last testing date was January 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. This was last conducted in December 2014

Staffing and recruitment

The three staff records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

The practice used the NHS care records service (CRS) smart card as proof of identity for some staff. The CRS smart card is used by some practice staff to access NHS care records. The CRS smart card has the name, photograph and the unique user identity number of the staff concerned. The practice had recruitment procedures that set out the standards it followed when recruiting clinical and non-clinical staff. However these procedures were not explicit on how the practice checked the identity of other staff who did not access the NHS Care Records Service (CRS). Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 requires such checks for all staff.

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. Staffing was usually reviewed during partners meetings and we saw evidence of these discussions. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. The practice manager told us that this policy was currently under review and was scheduled to be completed by September 2015. Health and safety information was displayed for staff to see and the practice manager was the identified lead for health and safety.

A GP told us about the arrangements for patients with long term conditions and children if their health deteriorated quickly. These included direct access to a doctor or a nurse either in person or by telephone.

The practice participated in the unplanned admissions enhanced service (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the practice had a system to follow up patients that were admitted to hospital and to take measures to prevent reoccurrence for those patients at high risk of admission to hospital.

Data from the Quality and Outcomes Framework (QOF) showed that patients from the practice were less likely to be admitted to hospital in an emergency for conditions such as cancer or other long term conditions. The practice manager told us that such patients were monitored by a care co-ordinator who reviewed their needs and ensured adequate arrangements for their care.

Identified clinical risks were discussed at clinical meeting and we saw record to confirm this. For example, unplanned hospital admissions.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. Staff members, knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available at the practice and staff knew their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

Good

Are services safe?

included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire systems check that included actions required to maintain fire safety. Records showed that staff were up to date with fire training.

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. This was through a system called 'Pathfinder' which incorporated all such guidance and offered GPs up-to-date access to diagnosis, treatment and monitoring information in one place.

Where new guidelines were disseminated, the implications for the practice's performance and patients were discussed during clinical meetings and we saw records of this. 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 nurses that staff completed thorough assessments of patients' needs in line with current best practice guidance, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart and lung disease and mental health and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We reviewed the data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last three years. Audited areas included childhood immunisation, contraceptive implants and minor surgical procedures. Of all these audits three were repeated over two years and only one had indicated the need for change in the initial audit. The practice had acted on this and introduced a system to obtain written consent for minor surgical procedures. A GP told us that future arrangements for clinical audits included a requirement that each GP would complete at least one audit each year.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The team was making use of, appraisals and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement. They also told us that the GPs and the practice manager had an open door policy which allowed them to reflect with them on the outcomes being achieved and areas where this could be improved.

The practice had a palliative care register and had regular contacts with the multidisciplinary team, for example the district nurse and the Macmillan service where the care and support needs of patients and their families were discussed.

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 arrangements for the appraisals of new staff who had monthly reviews for the first three months of their

Good

Are services effective?

(for example, treatment is effective)

employment and then yearly reviews. For other staff appraisal arrangements were ad hoc and were not planned to occur at regular intervals. The practice manager told us that they operated an open door policy which allowed staff to access a GP or other senior staff any time if they needed advise and support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, nurses that supported the GPs were skilled in diabetic care.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. The GPs were either validated or had a scheduled programme for revalidation. The practice nurse was supported to attend updates to training that enabled them to maintain and enhance their professional skills.

The practice had a process to manage poor performance.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. There was a system for such things as patient pathology results and radiology reports to be received electronically and allocated to the GPs. The process included a system of alerts for patients who required a follow up. For example we saw that the practice had tried several times to contact a patient who had abnormal blood results so they could be reviewed for any further treatment they may need. All the staff we spoke with understood how the system was used.

The practice held a clinical meeting every Monday to discuss the needs of complex patients. This included those with end of life care needs or children who were subject of a child protection plan. Clinical staff such as the district nurses, health visitors and the community mental health team were invited as appropriate to attend these meetings.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider and East Midlands Ambulance Service NHS Trust to enable patient data to be shared in a secure and timely manner. There was a process for making electronic referrals through the 'Pathfinder' system and 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.

An electronic patient record was used by all staff to coordinate, document and manage patients' care. We spoke with staff who told us they were trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that 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. GPs told us that they had undertaken training in Mental Capacity Act 2005 in 2014 through the British Medical Association.

The staff we spoke with demonstrated an understanding of the MCA and its implications for patients at the practice. Staff were also aware of the Gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge). The staff we spoke with gave examples of its use in the practice.

Consent for minor surgical procedures were obtained from patients and these were scanned into individual patient records. We saw an audit competed in 2014 which showed that consent had been obtained for all 20 minor surgical procedures that were performed.

Health promotion and prevention

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations were offered and we saw data that demonstrated the practice was in line with the local clinical commissioning group (CCG) average in the uptake of childhood immunisations. The practice had identified the smoking status of all patients with physical and/or mental health condition. Smoking cessation clinics were available and the health care assistant who provided these clinics offered patients a variety of smoking cessation advice. The practice also took part in the cervical screening programme. National data showed that the practice performance in cervical screening was in line with the local CCG average.

Good

Are services effective?

(for example, treatment is effective)

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 33 patients with a learning disability. Annual health reviews were routinely carried out for these patients. The practice also reviewed patients with a mental illness and 92% of patients had a comprehensive, agreed care plan documented in their records, in the preceding 12 months.

The practice offered travel vaccines and flu vaccinations in line with current national guidance. The Quality Outcome Framework (QOF) data showed that the practice was in line with national standards in providing flu immunisations for the target groups of patients.

Patients with long term conditions such as diabetes and respiratory conditions were regularly recalled for health monitoring.

The evolving needs of every patient receiving care at the end of their lives were discussed at the weekly clinical meetings during which the needs of specific patients and their cares or relatives were also considered.

When new patients registered at the practice they were provided with information about other local services. The practice also ensured that patients identified as carers were given appropriate information for carer support and noted within the patient information system as a carer

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 109 replies to the national GP patient survey carried out during January and July 2014.

Our review of the latest national GP patient survey showed that patients had a differing experience of whether they were treated well by either the GPs or the nurses. For example, the percentage of patients who experienced nursing staff who were good at treating them with care and concern or good at giving them enough time was 81 and 82% respectively; in line with the national average. Conversely, the experience of patients who felt the same way about their experience of the doctors at the practice was around 52 and 53% and this was lower than the average.

During our inspection we observed that patients were treated with dignity and respect. All of the patients we spoke with on the day confirmed this experience. They told us the staff were caring, kind, friendly and treated them with dignity and respect. Nurses and doctors had listened and responded to their needs and they felt involved in decisions about their care.

Staff were respectful, empathetic and dignified when interacting with patients including those that visited the surgery and those who called on the telephone. Staff dealt with patients' questions and concerns in a helpful and sympathetic way.

This was also borne out by the comments we received from patients who had completed comment cards in advance of our visit. Comments were positive and spoke highly of the attitudes and behaviours of staff towards patients. They commented the staff were caring, kind, friendly and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care.

Consultations took place in private where the doors to the treatment rooms were closed during such consultations. Privacy curtains were also available in all the consultation rooms.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

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.

However in the national GP patient survey patients had responded less favourably to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the survey showed 50% of practice respondents said the GP involved them in care decisions and 57% felt the GP was good at explaining treatment and results. Both these results were below the local CCG average.

The practice manager told us that the GPs were aware of the need to improve patient experience of the consultation and had taken action which included offering longer appointments to fully engage with the patient. The practice has now commissioned an independent company to collect detailed, accurate and timely monitoring of patient experience so patient experience could be regularly monitored and acted upon.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care.

Where older people had multiple health needs the practice had arrangements with the nursing team to follow up patients' needs in a flexible way, avoiding multiple appointments.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

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

Notices in the patient waiting room, and on the practice website 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. There was information available on the practice website for carers to ensure they understood the various avenues of support available to them. This included signposting to Northamptonshire Carers, a countywide service which offered support to carers and young carers.

We saw that a process was in place at the practice for recently bereaved patients to be highlighted on the electronic patient records system. The practice manager and the nurses told us that patients who were recently bereaved were contacted by the GP or practice nurse to ascertain what support they required. This resulted in a formal referral being made to either the local NHS trust counselling service or to a bereavement support organisation.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example the practice had regularly reviewed with the local CCG, the treatment needs of patients aged 75 or over who had increased bone fragility and susceptibility to fracture so an increased number of such patients could be treated with an appropriate bone-sparing agent.

There was a named GP to look after the care needs of patients over 75 years old. The GP or a designated nurse made home visits for those patients, included provision of the flu immunisation when required.

For people with long term conditions such as chronic obstructive airways disease (COPD) and asthma the practice operated a telephone triage system which allowed access to same day medical advice and care. Home visits were available where needed. This included people who lived in care homes.

The practice operated a register of patients that needed support with their learning disabilities which ensured appropriate care for these patients.

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

For children and young people the practice offered appointments outside of school hours Monday to Friday till 5.45pm.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a result of feedback from patient surveys. For example, the practice had made changes to the appointment system to try and achieve the right balance between triage calls for minor illness and advice, and the number of appointments needed to be available for routine follow-ups for long term conditions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff were aware of patients for whom English was not their first language. They said they could access a translation service if required. The practice website had a facility whereby its content could be translated into commonly encountered European, Asian and Middle Eastern languages immediately.

The practice had not arranged specific equality and diversity training. However the staff we spoke with had a good understanding of equality and diversity. Any specific issues were discussed during practice meetings and staff were actively asked for their opinions and views.

There were facilities for patients who used a wheelchair such as fully automated doors at the main entrance to the practice and same level flooring throughout. The clinical and consultation rooms were available on the ground floor and a toilet for patients with disabilities including grab rails and alarm. There was a hearing loop available at reception to help patients with hearing difficulties. The practice had disabled parking available. We noted that there was no designated facility for mothers to breast feed their babies. The practice manager told us that mothers would be directed to a vacant room in the surgery for breast feeding if required.

Practice staff told us they knew the patient list well and flexible appointments in terms of time and length of appointment times could be accommodated based on their specific needs.

The practice operated a policy to care for patients without stigma or prejudice. Homeless patients for example were able to register the same way as other eligible patients and the practice a flexible approach when providing to the needs of the individual.

Access to the service

Appointments were available from 8.30am to 12.30pm and from 2pm to 5.45pm on weekdays. Patients could request appointments in person by telephone or on line through the practice website. The practice triaged all requests for appointments for minor illness. On receipt of a request, this would be referred to a GP or a nurse. On triage they would either offer the patient a telephone consultation and advice or ask the patient to attend for a face to face consultation which could be on the same day depending on urgency. Follow on consultation if needed were pre booked either by the GP or the nurse and requests for home visits also underwent a similar triage process.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Routine appointments for long term conditions, immunisations and cervical cytology were usually sent in advance by the practice.

Comprehensive information was available to patients about appointments in the practice leaflet and on their website. Information provided included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, a recorded message gave the telephone number they should ring for the out-of-hours service.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available to housebound patients and to patients who lived in care homes.

Patients were generally satisfied with the appointments system. Information from the national GP patient survey showed that 97% of those who responded found the last appointment they got was convenient. Patients we spoke with confirmed that they could see a doctor 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. In three out of the 18 comment cards we received, patients had noted their frustration at the long process of triage and commented that the wait for a call back from the GP or the nurse was long.

Listening and learning from concerns and complaints

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

Information on how to make a complaint was available in the practice in a poster, leaflet and on the website. 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.

A complaints log was kept and we reviewed the complaints received in the past year and found that these had been investigated and responded to in a timely manner. The practice manager told us that complaints received were discussed during practice meetings so they were able to learn and contribute to determining any improvements that may be required. We reviewed the minutes from practice meetings which showed evidence of discussion shared learning. For example the practice had reviewed how bad news was given to patients and had shared this with all clinicians. Staff we spoke with were aware of the system in place to deal with complaints.

We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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. Their vision was to help patients to be well for the longest time and to preserve their dignity at the end of life.

The practice had short term and medium term plans to maintain and improve good outcomes for patients. This included meeting the requirements of the Quality and Outcomes Framework (QOF), increasing the physical size of the practice, making available more GP consultation hours and setting up a patient participation group during 2015.

We spoke with a number of GPs nurses and other staff and they all knew the provision of high quality care for patients was their main priority and knew their responsibilities in making this vision a reality.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff through the shared drive on any computer within the practice. We randomly looked at five of these documents and found that these had recent review date.

The practice had recently introduced an electronic system which allowed staff access to policies, guidelines and information through third desktop computers.

The practice used the quality and outcomes framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings including discussions with the local CCG to maintain or improve outcomes.

The practice was part of a locality group hosted by the local CCG and took part in local external peer review which included sharing good practice and learning.

Clinical audits were undertaken by the practice. We were shown records of completed audits the practice had undertaken during the past three years. These included audits on childhood immunisation, contraceptive implants and minor surgical procedures. As a result of these improvements had been identified and implemented.

The practice had a system for capturing any significant events that had occurred. The information from the significant events was analysed, reviewed and an action plan with learning points completed. The practice used this information to minimise the risk that may have affected patient care and/or quality of service.

The practice held regular clinical and other meetings where performance and related governance issues were discussed. We looked at minutes of these meetings and found that performance, quality and risks had been discussed. Examples of items discussed included compliance with the QOF requirements, issues with clinical decisions, prescribing, administration, access and appointments.

Leadership, openness and transparency

The practice had three GP partners who together with the practice manager provided a stable leadership. Staff told us they were well supported by GPs and the practice manager who were always approachable and open.

There was a leadership structure which had named members of staff in lead roles. For example there were named leads for safeguarding, infection control and complaints management. Staff we spoke with were clear about their roles and responsibilities and knew who to go to for support. They told us they felt valued, well supported.

Team meetings were held regularly, at least monthly. These meetings which included training on specific subjects were attended by all practice staff. 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.

A staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the national GP patient survey, their website, comments left on NHS Choices website and complaints process. For example we saw that the practice acted on comments received, had reviewed how bad news was given to a

Are services well-led?

Good

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

patient and had shared this with all clinicians. A GP told us that they had now started responding to individual comments left on NHS Choices inviting patients to discuss the issues raised with a GP or the practice manager.

The practice had commissioned a local survey of patient satisfaction in 2014. The report and the action plans following this survey were made available on the practice website. Actions included improvements to continuity of care by increasing GP consultation sessions and to the telephone triage system so more face to face appointments were made available.

The practice gathered feedback from staff through a variety of methods such as, staff meetings, appraisals and giving staff open access to the practice manager and GPs. Staff told us they were content to give feedback and discuss any concerns or issues with colleagues and management.

Staff told us they were aware of the whistle blowing procedure and would feel comfortable to implement it.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The whole practice team had training sessions at least each month. This occurred for half a day each month and was used for training and to give staff the opportunity to spend time together for peer support and sharing of experiences. A variety of clinical and non clinical topics were covered, for example safeguarding children.

The practice used the results of significant event analyses and clinical audit to improve performance and contribute to staff learning.