North Shore Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
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 North Shore Surgery 23 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all the population groups. It required improvement for providing safe services.

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, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified. However, records of further planned training were not well developed.
- 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. However, patients we spoke with were not aware of the procedure.
- Patients said access and getting an appointment was usually satisfactory. Urgent appointments were available each day.
- The practice was located within in a modern multipurpose building with access to leisure facilities,

Summary of findings

community health care services and local government offices. The practice facilities were spacious, were accessible to patients with disabilities and were fully equipped to treat patients and meet their needs.

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider must:

- Ensure recruitment arrangements include all the required pre-employment checks for all staff.

In addition the provider should:

- Introduce a system to ensure that clinical audits are planned and structured so that the practice benefits form the outcomes of those undertaken.
- Ensure periodic analysis of complaints and patient feedback is carried out to identify themes and trends so that appropriate action can be taken if required.
- Ensure a staff training matrix is recorded so that staff training needs are monitored effectively and future training can be planned for more efficiently.
- Ensure a succession plan is developed and implemented to mitigate any risk to service delivery and quality in the event of a GP retiring.

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?

Requires improvement

The practice is rated as requires improvement 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. However there were significant gaps in the recruitment processes of new staff.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' 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, however systems to monitor and plan future training were not well established. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. The physical environment and staff approach to patients promoted good respectful communication. Data showed that patients rated the practice higher than others for some aspects of care. 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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were generally satisfied with the appointment system and that urgent appointments were 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

Summary of findings

was available, although some patients were not aware of the procedure. Evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision which had quality patient care as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements were proactively reviewed. We found there was a high level of staff engagement with an open door policy for access to all senior staff. Staff told us they were very satisfied with their roles. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than average number of patients with long standing health conditions (62.2% compared to the England average of 54%). Patients with long term conditions were supported by a trained healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. Patients had health reviews at regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions including cardiovascular disease, diabetes, asthma and chronic obstructive pulmonary disease. These registers enabled the practice to monitor and review patient conditions effectively and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice supported diabetic patients by initiating insulin therapy at the practice.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. The practice offered a full range of childhood vaccinations and had systems in place to follow up children who did not attend for these. Monthly meetings were held with the health visitor. The practice provided a full family planning service with contraception advice, implants and

insertion of intrauterine device (IUD). The practice was resourced and staff were trained to treat advanced non-complicated sexually transmitted infections to both registered and non-registered patients.

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. For example the practice offered appointments until 8pm two evenings per week. The practice offered cryotherapy and acupuncture to its patients. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group including NHS health checks for patients between 40-74 years of age.

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 with a learning disability. Staff were trained appropriately and knew how to recognise signs of abuse in vulnerable adults. The practice 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. The practice had established working relationships with health care professionals such as the district nurses, community matrons and health visitors to make sure appropriate treatment and support was provided to patients identified as being vulnerable.

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 poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. The practice worked with multi-disciplinary teams and other mental health services in the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

We received 10 completed CQC comment cards; all were positive about the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us that the practice environment was clean and hygienic.

During our visit, we spoke with six patients. They told us that the GPs and nurses working at the practice were very good. They told us that the GPs, the care they received and access to appointments was generally good. They liked the text messaging appointment reminder service. We also spoke with two members of the practice's patient participation group (PPG). They told us that the practice listened to them. They told us of two recent examples where the practice had responded to their requests for improvements.

The results of the National GP Patient Survey published in July 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG). For example, 96% of respondents stated that the receptionists at the surgery were helpful (CCG 88%); 88% of respondents would recommend this practice to someone new to the area (CCG 81%) and 85% said they found it easy to get through to the surgery on the phone (CCG 78%).

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all the required pre-employment checks for all staff.

Action the service SHOULD take to improve

- Introduce a system to ensure that clinical audits are planned and structured so that the practice benefits form the outcomes of those undertaken.
- Ensure periodic analysis of complaints and patient feedback is carried out to identify themes and trends so that appropriate action can be taken if required.
- Ensure a staff training matrix is recorded so that staff training needs are monitored effectively and future training can be planned for more efficiently.
- Ensure a succession plan is developed and implemented to mitigate any risk to service delivery and quality in the event of a GP retiring.

North Shore Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, a GP and a specialist advisor who has experience of practice management.

Background to North Shore Surgery

North Shore Surgery is located in Blackpool and is part of the Blackpool Clinical Commissioning Group (CCG). Services are provided under a general medical service (GMS) contract with NHS England. According to data supplied by the practice, there are 11700 registered patients.

Information published by Public Health England rates the level of deprivation within the practice population group as four on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male and female life expectancy in the practice geographical area reflects the England average of 79 years for males and 83 years for female.

The practice offers extended opening hours from 8am to 8pm Monday and Wednesdays and 8am to 6.30pm on Tuesday, Thursdays and Fridays. Patients requiring a GP outside of normal working hours are advised to contact the out of hours service provided by Fylde Coast Medical Services (FCMS).

The practice has five GP partners, four male and one female. There is also one female salaried GP working at the practice. The practice employs a business manager, six female practice nurses including one clinical manager and one nurse prescriber, two male pharmacists, three female health care assistants, two prescription clerks, a non clinical manager, a reception supervisor, an administration supervisor, and reception and administration staff. The practice is a teaching practice for undergraduate student doctors and nurses and is a training practice for FY2 doctors. (A FY2 is a medical practitioner undertaking a two-year, general postgraduate general practice training programme).

The practice provides online patient access that allows patients to book appointments, order prescriptions, check test results and manage their clinical records.

The practice is housed in a purpose built modern building that is accessible to people with disabilities. The building provides a range of other community services such as podiatry, physiotherapy, pharmacy and includes a swimming pool and gym.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service to provide a rating for the service under the Care Act 2014.

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

Detailed 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. The population groups are:

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the business manager provided before the inspection day. We carried out an announced visit on 23 July 2015.

We spoke with a range of staff including three GPs partners, one salaried GP, the business manager, one clinical nurse manager, two practice nurses, two health care assistants, one pharmacist, one prescription clerk, one non-clinical manager and one administrator. We sought views from patients and representatives of the patient participation group, looked at comment cards, and reviewed survey information.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. This included reviewing 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. Minutes of meetings provided evidence that incidents, events and complaints were discussed, and where appropriate, actions and protocols identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints 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. We reviewed records of six significant events that had occurred during 2015 and saw this system was followed appropriately. The practice held weekly clinical meetings (Clinical Club) where significant events were discussed. 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 as an incident or significant event.

National patient safety alerts were disseminated by the clinical manager to relevant staff. Staff confirmed they received these by email.

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 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, document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to all staff.

All GPs at the practice had the required level 3 training in safeguarding children and vulnerable adults. The practice had appointed a dedicated GP as the lead in safeguarding. The clinical manager supported the GP and both had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

GPs were using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP and the clinical nurse manager were both aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. We saw minutes of meetings where vulnerable patients were discussed.

There was a chaperone policy, which was visible in the patient waiting room noticeboard. (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). It was the practice policy that only qualified nursing staff undertook the role of chaperone. If a nurse was not available to undertake this role we were told that the patient would be requested to make another appointment so that a chaperone could be organised. This we were told occurred very rarely.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Each of the dedicated pharmaceutical fridges used by the practice had an electronic temperature recording device within it. This measured the temperature at 15 minute intervals and logs of these recordings were kept and reviewed. These

electronic temperature records were also supplemented by manual fridge temperature monitoring and recording. The monitoring of fridge temperatures ensured medicines were stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice employed two pharmacists who reviewed the practice's prescribing trends, reviewed patient repeat prescriptions and ensured updated guidance and best practice was followed to ensure safe management of medicines.

Medicines for use in medical emergencies were securely stored but accessible to staff. All staff knew where the emergency medicines were stored. The clinical manager ensured that stocks of all medicines and their expiry dates were monitored and recorded regularly. There was oxygen and an automatic defibrillator (used in cardiac emergencies) kept by the practice for use in case of an emergency. These were checked regularly.

GPs bags also contained a small stock of emergency medicines and these were all within their expiry dates.

Cleanliness and infection control

We saw the premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. We saw audits that confirmed that monthly checks were carried out to monitor the cleanliness of the practice. Patients we spoke with told us the practice was always clean and tidy. They told us that clinical staff washed their hands and used gloves appropriately.

The clinical manager was the lead for infection control. They kept themselves up to date with good practice guidelines and liaised appropriately with external infection control professionals when they required additional guidance. Staff received training about infection control specific to their role. Records of infection control audits were available and we were told of the actions taken by the practice to improve infection control practices.

Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected treatment and clinical rooms. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and wipes were available in the treatment/consulting rooms. Couches were washable in the treatment rooms and cleaned following each use.

We were told the practice only used instruments that were single use. Procedures for the safe storage and disposal of instrumentation, sharps and waste products were evident. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a risk assessment for the management of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). However, we heard that the contractor who was carrying out the PAT testing service was taken ill and only partially completed this task. The business manager confirmed the contractor was booked to return and complete this task. Medical equipment was serviced and calibrated annually.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, our review of three newer staff recruitment files showed that the policy had not been followed and the appropriate recruitment checks had not

been carried out. For example, application forms were not completed, full employment histories had not been obtained consistently, explanations of gaps in employment had not been recorded, references were not available and evidence that these had been requested was not available. Not all the files contained proof of identification and one clinical staff member had not had the appropriate checks through the Disclosure and Barring Service (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The business manager assured us that this person would not provide direct clinical services to patients until this check had been completed.

We saw evidence that demonstrated professional registration for clinical staff was up to date and valid. However, a central record of these checks was not held which effectively made monitoring the status of clinical registrations cumbersome.

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. There was an organisational structure in place with specific leads for each of the three teams (Clinical, Administration and Reception). The team had clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was appropriate; each person knew exactly what their role was and undertook this to a high standard. Each team ensured that staffing levels and skill mix were reviewed and maintained to meet patients' needs. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

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, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

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, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. Staff also told us of the successful teamwork and professionalism demonstrated by the whole team when they responded to a recent medical emergency.

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 and an automated external defibrillator. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. 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 could affect the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included for example power failure, flood and pandemic. The document also contained relevant contact details for staff to refer to.

A fire risk assessment was available that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that regular checks on the fire alarm system were carried out.

Staff described how they would alert others to emergencies by use of the panic button and on the computer system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us clinicians listened to them and they were confident in the treatment they received. All the clinicians we spoke with were familiar with, and using current best practice guidance. We saw minutes of clinical meetings that showed the staff considered best practice guidance and the implications for the practice and service delivery. Staff we spoke with all demonstrated a good level of understanding and knowledge of National Institute for Health and Care Excellence (NICE) guidance and local guidelines.

Staff described how they carried out comprehensive assessments, which covered all patients' health needs, and this was in line with national and local guidelines. 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 received regular health checks and were referred to other services if required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. Weekly clinical meetings (Clinical Club) were held and each clinician had the opportunity to discuss patients' health care needs. Clinical Club was held on the day of our visit and meeting minutes confirmed that this happened.

Clinical staff told us the practice focused on learning and developing to improve outcomes for patients. They said they were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of long-term health conditions. The clinical manager and the two practice nurse we spoke with told us that they were supported by the GPs and they felt able to discuss any concerns they had about a patient or the management of a patient's condition. We heard that updated guidance and research in relation to managing diabetes and the associated health care needs was implemented following regular review. For example, the practice had four nurses trained to support Type 2 diabetic patients to start on insulin treatment. Traditionally injectable treatment for Type 2 diabetes was managed by specialist diabetes services.

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 that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs continued to be met.

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.

Systems were in place to ensure all test results and hospital consultation letters received into the practice were reviewed by a GP. All results and letters were scanned onto the system daily.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular audits. Annual QOF data showed the practice had consistently performed better than the CCG and England average between 2010 and March 2014. Their score for 2014 was 98% compared with the CCG average of 97.2% and the England average of 94%. Clinical staff told us that each team member took responsibility to offer patients all the relevant clinical assessments such as for example blood pressure monitoring and diabetic foot checks.

GPs told us about the clinical audits undertaken. Our review of a sample of these identified that the clinical audits undertaken were influenced by the clinician's preferences and had not been planned or structured in a way to benefit the practice.

The practice worked with other GP practices within the Clinical Commission Group (CCG) and participated in monthly integrated care multidisciplinary team meetings to

Good

Are services effective?

(for example, treatment is effective)

discuss the care and support needs of patients and their families in the local neighbourhood. Minutes from these meetings were available. Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

The practice had made use of the gold standards framework for end of life care. It 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 kept a register of patients identified as being at high risk of admission to hospital. Structured annual reviews were also undertaken for people with long term conditions such as diabetes, chronic obstructive pulmonary disease and cardiac failure.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff were overwhelmingly positive and enthusiastic about working at the practice. They told us that the patient was central to the services they provided and were clear how their work contributed to and impacted overall on the service provided. They said they felt involved, supported and trained to provide a good standard of service to patients.

The practice had a strong commitment to training its staff, however a staff training matrix detailing what training staff had received and when was not available. A training matrix is useful for monitoring and planning future training. Staff training records were kept with individual personnel files. All staff had access to a staff handbook, which included a range of employment policies and procedures. This was being reviewed and updated. Staff also had easy access to online policies and procedures including safeguarding, clinical policies, employment and health and safety.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example two practice nurses had recently completed ARTP Spirometry courses to assist in monitoring patients with breathing conditions such as chronic obstructive pulmonary disease (COPD).

As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries and information from out-of-hours GP services both electronically and by post. Relevant staff knew their responsibilities 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 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.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hours services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings. We saw a variety of documented meetings between the staff teams, which confirmed good working relationships between them and good review and joint decision making in patient care.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference.

Consent to care and treatment

All clinical staff we spoke with demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and their duties in respect of this. GPs we spoke with told us that they had training for this and the Deprivation of Liberty Safeguards

Good

Are services effective?

(for example, treatment is effective)

(DoLS). Staff gave us 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 are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, an electronic template was completed for joint injections. Patients were given supporting written information about these injections so they could make an informed choice before having the injection. Verbal and implied consent was obtained for insertion of intrauterine devices (IUD) and child immunisations with documentation of the explanation about the procedure and any risks discussed recorded in the patient's electronic record.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients about the services available via their website and in leaflets and posters in the waiting area. This included smoking cessation and travel advice.

The practice provided Tier 2 sexual health screening to their registered patients and non-registered patients. A Tier 2 service meant the practice was resourced and staff were trained to treat advanced non-complicated sexually transmitted infections.

The practice nurses held a variety of clinics including a weekly baby clinic and mixed clinic for specific long-term conditions and general health checks The health care assistant provided a lifestyle management support service to patients. This included discussions about the patient's environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency. The practice also operated NHS health checks for patients between 40-74 years of age.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results of the National GP Patient Survey published in July 2015 demonstrated the practice performed well when compared with the average results for the local Clinical Commissioning Group (CCG). For example, 96% of respondents stated that the receptionists at the surgery were helpful (CCG 88%); 88% of respondents would recommend this practice to someone new to the area (CCG 81%) and 85% said they found it easy to get through to the surgery on the phone (CCG 78%).

The six patients and two members of the patient participation group (PPG) we spoke with all told us that the GPs and nurses working at the practice were very good. They told us that the GPs and nurses respected their privacy and they were treated with dignity. The comments from patients were reflected in the detailed responses recorded on many of the 10 CQC comment cards we received.

The practice participated in the Friend and Family Test and submitted each month the returned questionnaires to NHS England. The business manager also reviewed the returned questionnaires and recorded the results from these, although there was no analysis undertaken to identify any themes or trends. The practice did not offer patients a suggestion box for them to share their views.

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The reception desk was open and accessible and this staff said allowed for better and more open communication with patients and promoted positive relationships. The computers at reception were shielded from view for confidentiality and staff took patient phone calls in a separate office away from the main reception area.

Consultations took place in rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. The GPs walked out to personally call patients into their consultation. This behaviour underpinned the practice ethos of respectful patient centred care. The patients we spoke with told us they were always treated with dignity and respect.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 87% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments. 99% said they had confidence and trust in the last GP they saw or spoke to and 79% said the last GP they saw or spoke to was good at involving them in decisions about their care.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

The practice told us that all patients over 75 years had a named GP and care plans were in place for patients with palliative care needs and those at risk of unplanned admissions to hospital. In addition, care plans were available for some diabetic patients (diabetes personal prescription care plan) and some patients with chronic obstructive airways disease. We reviewed a sample of anonymised care plans and these contained detailed clinical information but did not evidence clearly the patient involvement and agreement with these.

Staff told us that translation services were available for patients who did not have English as a first language. Double appointments were provided when translation services were required.

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations. Detailed information was also available on the practice's website about a range of support services that patients could access. Their website also contained a section headed 'Manage Your Health', and this contained information on pregnancy, childhood ailments, common ailments, long-term care and the 'useful information' section contained information on bereavement and counselling.

GPs told us they provided support to their bereaved patients. One patient we spoke with told us of the 'invaluable' support they received when their spouse died.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice monitored the service it provided and listened to patients. It was responsive to patients' needs and evidence was available demonstrating it was adapting to improve and maintain the level of service provided. For example, the practice provided a Tier 2 sexual health service, a full family planning and contraceptive service, cryotherapy and an acupuncture service.

The practice held information and registers about the prevalence of specific diseases within their patient population. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. The practice also supported patients who had lived in care homes and supported accommodation. They had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes and patients who were housebound received visits from a member of the nursing health care team to ensure health checks and vaccinations were not missed.

Tackling inequity and promoting equality

The practice was housed within a purpose built modern building, which also included two other GP practices, local authority offices, physiotherapy and podiatry service as well as a public swimming pool and gym. The building was adapted to meet the needs of people with disabilities. The GP practice was located on the first and second floor of the building, although all consultations took place on the first floor.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice populations' needs and provided a good service to all patient population groups.

Staff told us they had access to translation services although we were told that they rarely needed to use this service.

Access to the service

The practice offered extended opening hours from 8am to 8pm Mondays and Wednesdays and 8am to 6.30pm on Tuesdays, Thursdays and Fridays. The practice information booklet, available on the practice website, contained details about who to contact for advice and appointments outside of normal working hours and the contact details for the out of hours medical provider.

The practice offered a range of appointments each day. These included pre bookable appointments and on the day emergency appointments. Patients could ring for an emergency appointment or telephone consultation each day. The patients we spoke with, CQC comment cards and the GP patient survey data all indicated that patients were satisfied with this level of access. The results of the National GP Patient Survey published in July 2015 showed that 97% of patients said the last appointment they got was convenient, 84% described their experience of making an appointment as good and 92% described their overall experience of the surgery as good. These results were all above the local Clinical Commissioning Group (CCG) and England averages.

Appointments with the practice nurses were tailored to meet the needs of patients, for example, those with long-term conditions and those with learning disabilities were given longer appointments if required. The practice nurses and health care assistants also undertook home visits to older patients and those vulnerable housebound patients to ensure they did not miss the treatment and support they required.

Listening and learning from concerns and complaints

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

We observed that the practice complaints leaflet was available to patients on reception and this was available with the policy on the practice website. However, the six patients we spoke with on the day of inspection told us that they were not aware of how to make a complaint. The staff we spoke with across different teams knew how to respond and support patients who wished to make a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the records of the 14 complaints received by the practice between August 2014 and June 2015. We saw the practice responded to complaints, investigating the concern, responding appropriately to the complainant, identifying improvements in service quality, and sharing learning and adapting practice. Staff spoken with verified that they were consulted and made aware of changes in procedures as a result of complaint investigations.

However we noted that there the complaints log appeared to identify a recurrent theme. We were told that an analysis of the complaints to identify trends and themes had not been undertaken. This type of analysis could potentially identify gaps in service delivery or staff training needs, which would enable the practice to plan and implement improvements in the services it provided.

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 support patients to stay healthy and to provide high quality, patient centred care. Their mission statement referred to using all resources available to secure "the greatest possible improvement to the Physical and Mental Health of the Practice Population" and "To provide a working environment in which all Members of the Primary healthcare Team are encouraged to achieve their maximum potential, in order to provide prompt, high quality healthcare". The staff we spoke with from the three teams (Clinicians, Administration and Reception) all understood the practice vision and were committed to providing a high quality service to its patient population.

Governance arrangements

There was a clear organisational and leadership structure at the practice with named members of staff in lead roles. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Staff we spoke with were motivated and wanted to be part of improving the service they provided.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy if required. Staff confirmed they were aware of how to access these. Policies and procedures we viewed were dated and reviewed appropriately. The business manager confirmed that they were in the process of reviewing all policies and updating them.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed consistently better than the Clinical Commissioning Group (CCG) and the England average for the last four years. The practice also monitored other data sources to benchmark performance and where issues were identified initiated action to improve.

Staff undertook a range of audits regularly. Minutes of meetings provided evidence that the outcome of the audits were discussed at team meetings.

Risk assessments and risk management plans were in place.

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of good clear leadership that articulated vision and motivated staff to provide a good service.

Discussion with some GPs identified that they were considering their future at the practice. However, we were told that a succession plan to ensure the continuity of patient care and services in the event of a GP leaving was not in place. This potentially was a risk to the service and a succession plan would mitigate this risk.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt valued and their views about how to develop the service were acted upon.

The practice held a number of different meetings at regular intervals that were documented. These included clinical, administrative, organisational, managerial and partner meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events.

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

Complaints were well managed. The practice investigated and responded to them in a timely manner. These were discussed with staff and were used to ensure staff learned from the issues identified when appropriate.

There was a small active Patient Participation Group (PPG). Members of the PPG we spoke with confirmed that the practice responded to issues they identified and gave two

Are services well-led?

Good

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

recent examples where action had been taken. They confirmed the practice was trying to increase interest and patient participation and membership of the PPG but this was not very successful.

Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events. A whistleblowing policy was available.

Management lead through learning and improvement

The practice worked well together as a team and held meetings for learning and to share information. The practice worked with the CCG to develop and improve services both for the practice and the wider locality. The practice was aware of and acting on areas that needed improving in their service delivery.

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals, which included looking at their performance and development needs. Staff told us they had good access to training and support to undertake further development in relation to their role.

The practice recognised future challenges and areas for improvement, complaints were investigated, reviews of significant events, and other incidents were completed and learning was shared from these with staff at meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered provider must ensure recruitment procedures are established and all information specified in Schedule 3 is available in respect of staff employed to ensure staff are safely and effectively recruited and employed.** **Regulation 19 (1), (2), (3) Schedule 3**