

The Green House Surgery

Quality Report

Redcar Community Hospital, West Dyke
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an inspection of The Green House Surgery practice on 12 May 2015 as part of our comprehensive programme of inspection of primary medical services. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led. In summary our key findings were as follows:

- The practice provided good, safe, responsive and effective care for all population groups in the area it serves.
- All areas of the practice were visibly clean.
- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep patients and staff safe.

- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes. They had worked hard to recruit staff to improve accessibility and continuity of care to the practice population.
- The service was well led and there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

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?

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.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. 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 for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Three patients spoken with said they did not find it easy to make an appointment with a named GP. Of the 40 CQC comment cards we received four reported lack of continuity of care because the GPs were trainees who only stayed for six months. We were told there were urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet

Good



Summary of findings

their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and they held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice is rated as good for the care of older patients. Nationally reported data showed outcomes for patients were good, for conditions commonly found in this age group. The practice offered proactive, personalised care to meet the needs of the older patients in their practice population. They had a range of enhanced services, for example, in dementia and end of life care. We saw how they responded to the needs of older people, offering home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

The practice is rated as good for the care of patients 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. These patients had a named GP and a structured annual review to check their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

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 higher than the CCG average for all standard childhood immunisations. We were told children and young patients 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 and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of these patients had been identified. The practice had adjusted the services

Good



Summary of findings

it offered to ensure they were accessible, flexible and offered continuity of care wherever possible. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living with a learning disability. Annual health checks for patients with a learning disability were offered, the uptake of these had been poor. Telephone contact to these patients prior to their appointments had improved the numbers who had taken up the physical health check. Longer appointments were made available for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Appropriate services were available for vulnerable patients. They were signposted and supported to attend in-house groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. They told us of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of patients experiencing poor mental health (including those with dementia). 97% of these patients had been reviewed in the last year. Some were seen opportunistically; when attending for other appointments to avoid multiple attendances. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Patients experiencing poor mental health could access support services within the practice as well as other voluntary organisations. There was a system in place to follow up patients who had attended accident and emergency (A&E), where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We received 40 CQC patient comments cards where we found very positive comments about the practice and the staff. We saw comments about the excellent care patients and their families had received from members of the clinical team. They said they were involved in all aspects of their care and the GPs and nurses explained everything to them. Some of the comments were from people who had been patients since the practice opened. There were four comment cards which expressed whilst they were very happy with their care and treatment, they were unhappy with the lack of continuity of care. They acknowledged this was due to GP trainees. However, they felt this had impacted on follow up of referrals to other health professionals. Another negative point was about not being able to see their preferred doctor on days and times convenient to the patient.

The friends and family test report showed the patients who had completed the forms were more than happy with the care and treatment they received from the range of practice staff.

We spoke with ten patients, from different population groups, including four members of the Patient

Participation Group. They all told us the staff were very helpful, respectful and supportive of their needs. They felt everyone communicated well with them; they were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were provided with a caring service.

Some of the most recent patient survey results showed:

- 92% of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good. Compared with the national average of 86%.
- 92% of respondents said the last GP they saw or spoke with was good at treating them with care and concern. Compared with the national average of 85%.
- 92% of respondents said the last GP they saw or spoke with was good at explaining tests and treatments. Compared with the national average of 87%.
- 27% of respondents stated that they almost always saw or spoke with the GP they prefer. Compared with the national average of 38%.

The Green House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, CQC inspector and a practice nurse.

Background to The Green House Surgery

The Green House Surgery is located in a purpose built building, Redcar Primary Care Hospital on West Dyke Road, Redcar.

The practice provides General Medical Services (GMS) under a contract with NHS England Middlesbrough, to the practice population of 7,400 patients. Our information shows fewer patients over the age of 85, which reflects the life expectancy within the area. The practice deprivation score is in one of the most deprived. The practice has four partners, three GPs (two female and one male) and one management partner. They are supported by two Nurse Practitioners (female) and a practice nurse team which includes registered nurses, a healthcare assistant and two phlebotomists. There is an administration team with specific roles identified and there is an assistant practice manager.

The practice is open from 8.00am – 5.30pm, Monday – Friday and has extended opening hours on Tuesday until 8pm; these appointments are pre-bookable.

The practice has opted out of providing Out of Hours services to their patients. The practice uses Northern Doctors Urgent Care Ltd, for it's Out of hours cover from 6pm–8am each evening.

A wide range of services are available at the practice and on site these include: X-Ray, audiology, podiatry, physiotherapy, vaccinations and immunisations, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease. There are counsellors and support groups available in the practice.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 May 2015. During our visit we spoke with a range of staff: these included GPs, Advanced Nurse Practitioners, members of the practice nurse team, managers and clerical and administration staff. We spoke with patients who used the service. We observed how people were being cared for

Detailed findings

and talked with carers and/or family members. We read comment cards where patients shared their views and experiences of the service. We reviewed the latest Friends and Family Test (FFT) survey results. (All NHS patients are given an opportunity to review the quality of care and treatment they received using the FFT).

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. However details were provided of monthly and annual reviews each year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held regularly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the assistant practice manager. They showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of error results with a blood testing machine. The manufacturer was contacted and they agreed to replace the machine. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by a variety of methods to practice staff, these included meetings, on-line tasks, emails, or by face to face contact. Staff we spoke with were able to give examples of recent

alerts relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any which were relevant to their practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received 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 aware of their responsibilities and knew how to share information and properly record documentation of safeguarding concerns. They told us how they would contact the relevant agencies in working hours and out of normal hours. These contact details were easily accessible.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. This was to ensure risks to children and young patients, who were looked after or on child protection plans, were known and the up to date information was reviewed. We were told there was frequent liaison with partner agencies such as, health visitors.

There was a chaperone policy, which was visible on the waiting room visual display unit and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone.

Medicines management

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed their policy.

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 current waste regulations.

We saw records of practice meetings noting the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. This information was co-ordinated by the Medicines Optimisation Pharmacist and the technician.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as an independent prescriber and she received regular supervision and support in her role; as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The GP specialist advisor checked appropriate patient records which confirmed the procedure was being followed.

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

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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 and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella this is a term for particular bacteria which can contaminate water systems in buildings. We saw records which confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment used was routinely tested and displayed stickers indicating the last testing date. However the IT equipment testing responsibility had recently changed. This had been added to the practice's

Are services safe?

schedule of testing. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Administration staff told us they covered all aspects of their roles to ensure patients had access to information when the practice was open. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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. The assistant practice manager showed us records to demonstrate 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. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and learning and updated actions were seen.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of cardiac arrest. The Tees-wide protocol for the treatment of cardiac arrest was to summon an ambulance via 999 whilst using CPR/ Defibrillator. The practice had an on-site defibrillator. 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 included power failure, adverse weather, unplanned sickness and access to the building. We were told of a recent incident, car park flooding, and how this was managed to ensure all patients were seen in a timely and effective manner. The business continuity plan was said to be effective when put into action.

The practice had carried out a fire risk assessment this included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this, recent sickness of a key member of staff, and the mitigating actions that had been put in place to manage this.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed 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 NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma 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. GPs told us this supported all staff to continually review and discuss, new best practice guidelines for the management of diabetes. Our review of the clinical meeting minutes confirmed that this happened.

One of the GP partners showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with

suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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 assistant practice manager and their deputy to support the practice to carry out clinical audits.

The practice showed us a number of clinical audits that had been undertaken in the last two years. We saw an audit where patients who had, had a splenectomy received the appropriate immunisation at five yearly intervals. There was a 100% uptake, this helped to improve their immunity and their health outcomes.

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). For example, we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 91% of patients with diabetes had an annual

Are services effective?

(for example, treatment is effective)

medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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

The practice had achieved and implemented 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. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice participated in local benchmarking run by the CCG. This benchmarking data showed the practice had outcomes that were comparable to other practices in the area. For example childhood vaccinations uptake.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors all had additional diplomas in

areas of particular interests. These included sexual and reproductive medicine, diplomas in children's health and obstetrics rheumatology and dermatology. All GPs were up to date with their annual continuing professional development requirements and all 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 these 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. As the practice was a training practice, doctors who were training to be qualified as GPs offered extended appointments and had access to a senior GP throughout the day for support. GP registrars were not placed with the practice on the day of our inspection.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, and cervical cytology. Those with extended roles such as management of diabetes and respiratory diseases were also able to demonstrate they had appropriate training to fulfil these roles.

Staff files we reviewed showed where poor performance had been identified appropriate action had been taken to manage this. These actions included regular performance reviews and where necessary further training was provided to ensure the safety of the practice's patients.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. They received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the 111 service reports both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers, on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their

Are services effective?

(for example, treatment is effective)

roles and felt the system worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy for actioning hospital communications was working well in this respect. The practice undertook an annual audit of follow-ups to assure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended, when appropriate, by district nurses, community matrons and palliative care nurses so decisions about care planning were agreed and documented in shared care records. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported the system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and this had been fully operational since December 2014. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

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.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These were used to help assess whether a child had 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, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that patients in this age group took up the offer of the health check. A GP showed us how patients were followed up within a week if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. Practice records showed that although the numbers were

increasing of those who had received a check up in the last 12 months, these needed to improve. The practice now telephoned these patients as well as sending invitations via the post; this had improved the uptake of these health checks. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 95%, which was better than some in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named administrator responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named administrator.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 92% of practice respondents saying the GP was good at listening to them and 87% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four comments were less positive although they were positive about the care and treatment they received, they were unhappy about the lack of continuity of care. The four members of the PPG we spoke with also confirmed that when they spoke with patients this was a recurring theme. They felt that this related to the GP registrars in training, who changed after six months. There was a new full-time partner appointed and they (The PPG) intended to revisit these concerns when they surveyed patients, in the future, to see if patient satisfaction with lack of continuity had improved. We also spoke with ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was

maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This helped to prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it helped confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the assistant practice manager. They told us they would investigate these and any learning identified would be shared with staff. There was evidence of learning taking place as staff meeting minutes showed issues had been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 88% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. Both these results were similar to expected locally and nationally. The results from the practice's own satisfaction survey March 2015, showed that 98% of patients said they were sufficiently involved in making decisions about their care.

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

Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, the respondents to the Patient Participant Group survey said they had received help to access support services to help them manage their treatment and care when it had been

needed. 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, on the TV screen and patient website highlighted to patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various support groups locally.

Staff told us if families had suffered a bereavement, their GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. This included recruiting and retaining clinical staff, such as GPs and practice nurses, which was a national and a local issue.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients with a learning disability were invited each year for a physical health check however; the number who had attended was low. The practice had decided to invite these patients personally via the telephone. This initiative had increased the take up considerably.

The practice had access to online and telephone translation services and a GP who spoke other languages. The practice had a population of 98.9% English speaking patients though it could cater for other different languages through translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was situated on the first floor of the building. There was lift access to the first floor. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 8.00am to 5.30 pm on weekdays. On Tuesday the practice was open until 8pm for pre-bookable appointments. Longer appointments were available for patients who needed them and for those with long-term conditions. This included appointments with a named GP or nurse. Patients who resided in care homes were visited when required.

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

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system; this was in the practice leaflet, on the website and on-going cycle on the practice television. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at ten complaints received in the last 12 months found these were satisfactorily handled. They were dealt with in a timely way. They used a good template and we found evidence of actions taken.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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. We found details of the vision and practice values were part of the practice's strategy and five year business plan. The practice vision and values included being patient centred and listening well.

We spoke with eight members of staff and they all knew and understood the purpose of the practice, and knew what their responsibilities were.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 11 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 11 policies and procedures we looked at had been reviewed annually and were up to date.

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

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 and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw evidence of increased patients who were on repeat prescriptions of drugs were being screened more effectively than in the previous audit. However, it was noted these numbers needed to be improved and subsequent audits were to be undertaken regularly.

The practice had arrangements for identifying, recording and managing risks. The assistant practice manager showed us the risk log, which addressed a wide range of potential issues, these included ensuring all referral letters to secondary care (hospital) are processed within 48 hours of the referral being instigated. We saw the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified. Action plans had been produced and implemented.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. 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. We also noted that team away days were held every six months.

The management partner was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that 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 patient surveys, comment cards and complaints received.

The practice had an active patient participation group (PPG). The PPG had carried out surveys and more recently met with patients in the waiting room to gain 'real time' feedback. This also enabled them to sign post patients where applicable to support services available. They met every month. The management partner showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they

Are services well-led?

Good 

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

would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had monthly clinical education meetings where guest speakers and trainers attended.

The practice was a GP training practice. This helped to ensure staff kept up to date with clinical guidance and new ways of working as diagnoses and treatment options were discussed each day and at weekly clinical meetings.

The practice used information such as the Quality Outcome Framework (QOF) and patient feedback to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services. The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.