Dr Khalid and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Khalid and Partners on 05 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

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

Importantly the provider should:

Summary of findings

- Implement a checking or audit system that enables them to identify patients at risk each time a medicine alert is received and to identify and manage prescriptions that have remained uncollected after an extended period.
- Collate complaints in the form of a log that enables such trends to be identified and the complaints and their outcomes to be monitored.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is safe and is rated as good.

The practice was consistent over time in its approach to dealing with safety incidents. 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 except that medicine safety alerts were not always responded to effectively. Risks to patients were assessed and properly managed. There were enough staff to keep people safe. The practice had plans in place to respond to events that might interrupt their service.

Are services effective?

Good

The practice is effective and is rated as good.

Data showed patient outcomes were at or above average for the locality. The practice monitored its effectiveness through the use of clinical audits. Staff referred to guidance from NICE and used it routinely. People'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 planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams for patients receiving end-of-life care. The practice ran a range of clinics to promote health and prevent ill-health. The practice was proactive at identifying patients who cared for others.

Are services caring?

Good

The practice is caring and is rated as good.

Data showed that patients rated the practice higher than or similar to others for the provision of a caring service. 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 responsive to people's needs and is rated as good.

Summary of findings

The practice understood the needs of its local population and engaged with the Clinical Commissioning Group (CCG) and local NHS trusts to help plan local healthcare services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded to issues raised.

Are services well-led?

Good

The practice is well-led and is rated as good.

The practice had a clear vision and strategy in the form of its published statement of purpose. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular multi-disciplinary governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients through the patient participation group (PPG), which it acted on. The practice leadership structure and its status as a training practice lent itself to a learning culture.

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 had a GP with a special interest of 'frail and elderly'. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services; for example, in dementia screening, flu clinics and end-of-life care. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice also served the needs of four local care homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

The practice proactively managed the recall and treatment of people with long term conditions and ran specific clinics and medication reviews. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. One of the GPs at the practice had a special interest in cardiology.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who might be subject of a child protection plan. The practice had a designated lead for safeguarding and staff were supported with clear procedures and training. Immunisation rates were similar to the national average for all standard childhood immunisations. Children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors and school nurses, such as ante-natal clinics. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of 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, extended early morning and late evening appointments twice weekly. 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 such as the NHS adult health checks and lifestyle clinics.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and data showed that all of these patients had received a follow-up. It offered longer appointments, and appointments out of scheduled times for people with a learning disability or for those with complex needs. People who were non-residents could access the service as registered temporary residents.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

97% of people identified as experiencing poor mental health had received an annual physical health check which was significantly higher than expected. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE and had a primary care liaison worker to facilitate a single point of entry to mental health services. The practice also had individually tailored care plans for people with poor mental health.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection including two members and the chair of the patient participation group (PPG), a group of patient's representatives and staff set up for the purpose of consulting and providing feedback in order to improve quality and standards. Everyone we spoke with reported that they were treated with kindness, respect and dignity by all the staff at the practice and that they were provided with plenty of information about their care and treatment. They also reported that they could easily get an appointment and that the practice was responsive to their needs.

We collected 39 comment cards that had been left for us by patients in advance of our visit. Only wholly positive experiences of patients were reported on the comment cards with none of the cards indicating any negative or critical views. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We looked at data from the 2014 National Patient Survey. We noted that 86% of patients stated they would recommend the practice with 91% stating that they felt the practice was good or very good; these were among the higher range of ratings nationally and higher than the average for this Clinical Commissioning Group (CCG). Generally the survey indicated a positive experience of patients with satisfaction rates similar to or higher than the national average for helpful staff, being treated with care and concern, opening hours and appointment availability (among the best nationally).

Areas for improvement

Action the service SHOULD take to improve

The practice should implement a checking or audit system that enables them to identify patients at risk each time a medicine alert is received and to identify and manage prescriptions that have remained uncollected after an extended period.

The practice should collate complaints in the form of a log that enables trends to be identified and the complaints and their outcomes to be monitored.

Dr Khalid and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by a GP specialist adviser and a Practice Manager specialist adviser.

Background to Dr Khalid and Partners

Dr Khalid and Partners, also known as Woodsend Medical Centre is a community general practice that provides primary medical care for just over 9,000 patients who live in the town of Corby, Northamptonshire and the surrounding area. According to Public Health England, the patient population is predominantly White British with a slightly higher than average percentage of patients aged under 49 years as compared with the rest of England. There is a less than average percentage of patients older than this. The practice is in an area considered to be in the lower 30% of deprived areas in England.

Dr Khalid and Partners has six GPs, four of whom are partners in the practice. There are four practice nurses and two healthcare assistants who run a variety of clinics as well as members of the community midwife and health visiting team who operate regular clinics from the practice location.

There is a fifth, non-clinical partner with governance responsibility. There is also a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.00am and 6.30pm, Monday to Friday. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme in accordance with our regulatory functions. 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them in this round of inspections in the Corby Clinical Commissioning Group (CCG) area.

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

We conduct our inspections of primary medical services, such as Dr Khalid and Partners, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

Detailed findings

We carried out an announced visit on 5 November 2014. During our visit we spoke with three of the GPs, the managing partner, the practice manager, members of the nursing team, administration staff and a GP registrar (an experienced doctor undergoing training to become a GP).

We spoke with five patients using the service on the day of our visit two of whom were members of the patient participation group (PPG), a group of patients that contribute views, activity and experiences to improve the quality of service. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 39 CQC comment cards completed by patients using the service prior to the day of our visit day where they shared their views and experiences.

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

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

We also look at how well services are provided for specific groups of people and what care is expected for them. Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

We found that Dr Khalid and Partners had an open and transparent culture amongst its staff about keeping people safe. This was supported by clear procedures for identifying risks and improving patient safety by escalating significant events and allegations of abuse for further investigation or discussion. These discussions took place during weekly multi-disciplinary team (MDT) meetings involving the clinical team and managing partner.

We looked at complaints records, comments received, records of incidents and notes of these meetings for the previous 12 months. These showed that incidents, feedback and concerns were discussed and acted upon. Staff we spoke with demonstrated a broad understanding of the processes for reporting such incidents and knew the extent of their accountability. We learned of occasions when this had taken place.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and analysing significant events, incidents and accidents, a process known as significant event analysis (SEA). All staff were empowered to report incidents and events and could determine whether an event was deemed to be significant and thus required further investigation or discussion by the weekly MDT. Outcomes and any learning arising from the incidents were communicated to staff during staff meetings.

We found that the practice were receptive to feedback and learned from it. For example, some suggestions we made to the practice about improving the structure of the significant event reporting template and the involvement of the practice manager at the MDT meetings were all positively received.

We saw that there had been seven SEAs in the 12 month period up to the date of our inspection and in each case we were able to track the recording process, the MDT discussion and the actions that had arisen as a result. For example, we saw that one SEA had led to the practice introducing a review process for checking attendances at hospital for referrals made under the 'two-week-wait' protocol for following up cancer assessments.

Reliable safety systems and processes including safeguarding

The practice had policies and systems in place to manage and review risks to vulnerable children, young people and vulnerable adults. There was a named GP lead for safeguarding and we saw that all staff had received training appropriate to their role. Effective safeguarding policies and procedures were in place and were fully understood and consistently implemented by staff. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities about documenting safeguarding concerns and how to contact the relevant agencies during and out-of-hours. We saw that information about the local authority's safeguarding process was readily available.

The practice had a four-weekly safeguarding meeting where patients who were at risk were discussed; any current concerns were also discussed at the weekly MDT meeting. There was an effective communication protocol in place that enabled information about patients at risk to be shared with other agencies.

There was a system to highlight vulnerable patients on the practice's computer system. Staff we spoke with told us that this included information on specific issues so they were aware of any relevant background when patients attended appointments; for example children subject of a child protection plan.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of communications from hospitals or other services. Access to this system was through a smartcard and a unique password. The practice used minimal paper patient records. Where paper records were used these were filed away securely after use in accordance with a clear desk policy which required all staff to lock away paper documents with confidential personal information.

A poster advertising the availability of a chaperone was visible to patients on the waiting room noticeboard and a policy was available for staff to refer to. Chaperone training had been undertaken by staff who carried out this role and patients we spoke with confirmed that they had been offered this service. A chaperone is someone who is present during an intimate examination whose role is to ensure that patients are safe.

Good

Are services safe?

Medicines management

We found that there were clear procedures for the management of medicines that minimised the potential for error. For example, we found evidence that the nursing team were working with patient group directions (PGDs) that were up-to-date, signed and held on the practice intranet. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before they present for treatment, such as vaccinations or family planning medicines.

We saw that the cold chain was maintained for the storage of temperature sensitive medicines, such as the flu vaccine, from the time they were received at the practice to the time they were administered. There was a system for monitoring the fridge temperatures daily so that the practice was assured the vaccines remained viable and safe to use.

All other medicines, including those used in a medical emergency, were stored appropriately and were checked monthly by the designated lead nurse who was in charge of medicines. We saw signed and dated entries in a log book which showed that there were also arrangements to check the medicines when the nurse was on leave.

Two members of staff who were dedicated prescription clerks managed all patients' repeat prescriptions on the computer system before they were handed to a GP for signing. This allowed an effective audit trail to be kept. The system also enabled staff to be alerted when a patient's medicines were due to be reviewed or if a patient had not requested a repeat prescription by the due date. For example, we saw that that the prescription clerks added blood test request forms to the prescription to remind patients they needed to have a blood test as part of their medicine review.

However, we found that there were some shortfalls in the repeat prescription process. For example, we noted that the file box in reception for prescriptions awaiting collection contained uncollected prescriptions that were significantly out of date. In two of the alphabetised sections there were more than 10 such prescriptions that were more than three months old. There was no system in place for retrieving these prescriptions and for following them up. Furthermore, a search of the data from the patient records management system and our discussions with the GPs showed that there was no system in place to identify patients who might be at risk as a result of medicine safety alerts. There were18 such patients that were still being prescribed medicines that had been subject of an alert where no medication review had taken place. In one case we noted that a patient had not received a medication review for 18 months.

The practice should implement a checking or audit system that enables them to identify patients at risk each time a medicine alert is received and to identify and manage prescriptions that have remained uncollected after an extended period.

Cleanliness and infection control

We saw that the premises were clean and tidy. Treatment rooms were maintained appropriately for this purpose. We saw there were cleaning schedules in place and cleaning records were kept that helped the practice to monitor the effectiveness of the cleaning process. For example, we noted that there were weekly records showing that the minor surgery rooms were deep-cleaned weekly by the healthcare assistants. We saw one such deep cleaning process being undertaken at the time of our inspection.

The senior nurse was designated as a lead infection control for the practice and was a point of reference for all staff. They acknowledged that the practice had not yet carried out an infection control self-assessment as recommended by the Department of Health guidance. However, we noted that there were sterilisation logs, curtain cleaning logs and check sheets for each of the consultation rooms. Even though an infection control self-assessment had not been carried out, the regular check sheets indicated that the practice had a diligent approach to monitoring cleanliness on a day-to-day basis.

Notices about hand hygiene techniques were displayed above every hand-washing sink in the treatment rooms and in all of the toilets. Hand-washing sinks were all equipped with hand gel and hand towel dispensers.

An infection control policy, which had been updated in September 2014, and supporting procedures were available for staff to refer to on the practice intranet and also in hard-copy form. 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 in order to comply with the policy. There was also a protocol to be followed in the event of anyone suffering a 'needle-stick' injury.

Good

Are services safe?

All staff had received annual infection control training and we noted that the last training session had been in January 2014. In addition, the GPs and the nursing team had received infection control training from the clinical commissioning group (CCG) alongside clinical staff from neighbouring GPs in May 2014.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings) and had carried out a risk assessment in June 2014. We saw records that confirmed the practice was carrying out regular checks of the water supply in line with this policy in order to reduce the risk of infection to staff and patients.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or hygienic practices.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was well equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the asthma clinic, and procedures, such as minor surgery. The practice also maintained an audit trail of equipment, such as surgical instrument packs and contraceptive devices, which enabled each instrument to be attributed to each procedure and to each patient.

Staff told us that all equipment was tested annually and maintained regularly under an agreement with the suppliers and we saw records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that relevant equipment such as blood pressure monitors, nebulisers, a spirometer and an electro-cardio gram (ECG) machine were properly calibrated to ensure they were operating safely and effectively.

Staffing and recruitment

We saw that the practice planned its staffing requirement around the services it provided. This was based upon the historic experience of meeting the needs of the community over time and a 'demand audit' that the practice had carried out 18 months prior to our inspection which was due to be repeated. This ensured that there were enough competent staff on duty with the appropriate skill mix at all times to support safe care and treatment. We saw that staffing had remained stable; there was evidence of a low staff turnover and minimal use of locum staff.

Staff rotas were set in advance and the staffing requirement was managed through the practice's computer system which identified when all staff were available. Staffing was monitored weekly through a capacity monitoring report produced for the practice management meeting showing how many appointments were booked for each GP and nurse. In this way, planned absences such as staff leave and unexpected absence due to sickness were managed and cover arranged as appropriate.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to people being employed. We saw proof of identification, references, qualifications, registration with the appropriate clinical professional body and, where applicable, criminal records checks through the Disclosure and Barring Service (DBS). All medical and nursing staff had checked through the DBS as well as all staff who had direct contact with patients and those who performed the role of chaperone. The practice was in the process of carrying out DBS checks retrospectively for all other staff.

Monitoring safety and responding to risk

We saw that the practice had procedures in place to deal with potential medical emergencies. All staff had received annual training in basic life support and in the use of an automated external defibrillator (AED). The AED and emergency oxygen were readily available and checked monthly. The practice carried a small stock of medicines for use in the event of a medical emergency such as a heart attack or severe shock due to an allergic reaction. We saw that emergency medicines were checked monthly to ensure they were within their expiry dates.

We found that staff at all levels were empowered to raise immediate concerns they might have about any particular patient with a clinician, even if they were unsure about what they had identified. Staff we spoke with said they were confident in recognising patients who might arrive at the practice with acute clinical needs requiring a clinician's input as a priority. We learned of instances when this had occurred.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. This plan was in draft form and had been circulated to the GPs on email at the time of our inspection and so was accessible from computers off-site. No hard copies were available. The document described the actions and responsibilities of all staff in the event of such an emergency and the relevant contact details. For example, we saw that local radio stations would be contacted in the event of the practice losing its telephone system.

The practice reviewed its risk assessments annually and made them available to staff through the practice intranet. For example, the fire risk assessment had been updated in August 2014 and a fire drill had taken place in the month before our inspection.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. This included the use of best practice and clinical guidance described by the National Institute for Health and Care Excellence (NICE and local guidance emanating from local commissioners of health services such as the Clinical Commissioning Group (CCG).

From our interviews with the clinical staff and a review of records of meetings, we saw that all the medical and nursing staff working at the practice took part in a weekly multi-disciplinary team (MDT) meeting. This meeting was set up with the principal purpose of reviewing clinical activity and improving practice. For instance, the latest NICE and other guidance was reviewed so that all staff would benefit from the most recent updates and their understanding enhanced through peer discussion.

Furthermore, individual prospective referrals were discussed to ensure consistency of approach and the appropriateness of referrals made to other services. The practice was able to demonstrate that their monitored referral rates had reduced since the introduction of the MDT meeting and that this reduction had been sustained over time. We also saw that individual patients with complex needs were discussed during the MDT to support their care planning. Antibiotic prescribing was also reviewed so that the practice understood their performance against national standards and in comparison with practices in the area.

We noted that the practice had used a risk identification tool to identify patients that were most at risk of repeated hospital admissions and were managing their care through individually tailored, proactive care plans. Additionally, we reviewed the records of weekly meetings held between the GPs, nurses and the MacMillan service that showed the practice had an active programme of monitoring the care and treatment of those patients who were receiving end-of-life care.

The practice had a diverse work force and we saw no evidence of discrimination in decision making about care and treatment decisions.

Management, monitoring and improving outcomes for people

We found that the MDT played a key role in monitoring and improving outcomes for patients. For example, as we noted above, the data about referrals was monitored by the MDT and this had shown a significant and sustained reduction over the two years prior to our inspection.

During our inspection we looked at 13 clinical audits that had been undertaken in the last six years. Two of these related to antibiotic prescribing and were re-audits of earlier audits carried out at the practice. Three further audits related to follow-up monitoring of the practice's response to patients with chronic obstructive pulmonary disorder (COPD). These were completed audits where the practice was able to demonstrate they had considered the findings, made changes and had assessed whether the changes had been effective. For each of the audits, the findings had been presented to the MDT by the clinician carrying out the audits to enable full, peer discussion and to agree any actions as a group. For example, we saw that the three COPD audits carried out between February 2013 and March 2014 had resulted in changes to the different types of therapy offered to individual patients over that period. Furthermore we saw data showing that the practice had made significant improvements in its prescribing behaviour in the two years prior to our inspection, moving from the worst to one of the best practices in the CCG area.

We noted that the practice used the information collected from the quality and outcomes framework (QOF) to monitor the way they provided their service. The QOF is a national performance measurement tool based on patient data and resulting in the award of points according to how well minimum standards are met. This data was also presented for discussion at the weekly MDT which allowed the practice to monitor their performance frequently and to respond quickly to any deviation. We saw that the practice had achieved a maximum award of points for the last three years which indicated that diagnosis and treatment was consistent over time.

We saw that the QOF data also indicated the practice were consistently performing to nationally expected standards for assessment and treatment of long term conditions such as diabetes, chronic heart disease and chronic kidney

Good

Are services effective?

(for example, treatment is effective)

disease. In some aspects of treatment the practice's performance was significantly higher than expected; for example, for COPD and the care of patients receiving end-of-life care.

Effective staffing

Practice staffing included clinical (GPs and nurses) and non-clinical roles (managerial and administrative staff). We looked at records and spoke with staff and found that all staff were appropriately trained and supported to carry out their roles effectively. This was the case for both clinical and non-clinical staff. For example, we saw that the practice developed an individual induction schedule for each member of staff depending on their level of experience and their training need. The programme involved shadowing an experienced colleague and carrying out their role in accordance with procedures until they were deemed suitable to work alone.

All clinical staff were appraised annually and undertook continuing professional development in order to fulfil the revalidation requirements of their professional bodies such as the General Medical Council and the Nursing and Midwifery Council.

All other staff received an annual appraisal. The practice had recently identified the need for training for those staff whose role required them to appraise other members of staff and we saw that this training had been procured. The practice closed for one afternoon each month and designated this period as 'protected learning time' (PLT). During PLT staff received both internal and external training in subjects which enabled them to carry out their role effectively, such as fire safety, basic life support and information governance. The practice monitored the attendance and frequency of staff training by means of a spreadsheet database which meant they had a clear picture at all times of their skill mix and training need.

The practice provided opportunities for staff development. For example, we noted that staff in administrative roles had been offered further recognised qualifications in customer service and business administration but there had been no take up of this training. In addition to this, nursing staff and healthcare assistants attended training that equipped them to carry out different tasks depending on their role. Such training included, for example, spirometry (a lung capacity measuring test), immunisation, insulin management and cervical sampling.

The practice was a training practice and afforded opportunities for registrars (experienced doctors training to become GPs) to develop their skills in general medicine. We saw that the established partners promoted learning through a mentoring programme that registrars found supportive and effective.

Working with colleagues and other services

We found that the practice engaged regularly with other health care providers in the area such as the district nursing team, the health visitors, the emergency department of the local hospital and the local ambulance service. All records of contact that patients had with other providers, including blood and other tests, were received by fax, post or electronically. Thereafter they were scanned or entered into the records system for clinical review and subsequent follow-up within 24 hours by the GP who last saw the patient. The exception to this was for those patients with difficult prescribing matters or patients with complex needs, all of whom were reviewed by a designated partner. We noted that there were no routine post hospital discharge visits carried out.

The evolving needs of every patient receiving palliative care were discussed at weekly multi-disciplinary team (MDT) meetings involving the GPs, nurses, social workers and the MacMillan service. As patients neared the very end-of-life, their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service and the out-of-hours service to ensure that specific wishes about their death could be met.

As reported above, we saw that all referrals to other services were peer reviewed at the weekly MDT meetings to enable a consistent approach to be taken and for the practice to be assured of the appropriateness of such referrals.

Information sharing

The practice used an established electronic patient records management system (known as SystmOne) to provide staff with sufficient information about patients. All staff were trained to use this system. The system carried personal care and health records and was set up to enable alerts to be communicated about particular patients such as information about children known to be at risk.

The system also enabled correspondence from other health care providers, such discharge letters or blood and other test results, to be scanned and held electronically to

Good

Are services effective?

(for example, treatment is effective)

reduce the need of paper held records. The practice system was also the gateway to the 'choose and book' system which facilitated the management of referrals on to other services such as the hospital outpatients. This system was readily available and accessible to all staff.

The practice had begun to use the electronic Summary Care Record system. The Summary Care Records provide key, clinical information about individual patients to healthcare professionals to enable faster access in an emergency or out of normal hours.

Consent to care and treatment

We found that patients' consent to care and treatment was always sought in line with legislation and guidance. This consent was either implied, in respect of most consultations and assessments or was explicitly documented in the case of minor surgical procedures. For such procedures the practice used template forms that were taken from the practice computer system; for example we reviewed a consent form for vasectomy. These forms explained the procedure or process in detail to enable patients to fully understand their treatment and to provide written, signed consent.

Patients we spoke with on the day of our visit told us that they were always provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

We also saw that the practice applied well-established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. We saw that the provisions of the Mental Capacity Act 2005 (MCA) were used appropriately and that assessments of patients thought to have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. This was particularly relevant for patients who had a learning disability or patients who lived with dementia. However we noted that there was no recent staff training in the MCA although relevant policies and guidance to support staff was available on the practice's intranet.

Health promotion and prevention

There was a range of up-to-date health promotion literature available in the waiting area with information physical and mental health and lifestyle choices. For example, we saw that there as information available on diet, smoking cessation, alcohol consumption, contraception. This information was also repeated on an information caption cycle on the TV screen in the reception area.

The practice ran health promotion clinics for long term conditions such as diabetes, asthma and heart disease and these were advertised in the practice information leaflet and on the practice web-site. Clinics were also held for smoking cessation, blood pressure monitoring and weight management. The practice had also been commissioned to provide an ear-wax clinic for patients from the town of Corby and a community skin clinic for patients with Basal Cell Carcinoma in Northamptonshire.

We saw that new patients were asked to complete a general health questionnaire when they first registered and were invited into the surgery to see a nurse for a health check and exploration of their medical history and lifestyle.

The practice proactively identified patients who were also carers and offered them additional support. Staff and clinicians were automatically alerted to patients who were also registered as carers by means of an alert on the computer screen. This ensured that doctors were aware of the wider context of the person's health needs. We saw that carers could also be referred to external carer support organisations that could provide additional practical and emotional support and the practice had a dedicated web-page for this group of patients. The practice had been commended for this work by the Northamptonshire Healthcare NHS Foundation Trust.

The practice hosted twice weekly ante-natal clinics run by the community midwife and weekly childhood immunisations clinics run by the practice nursing team. This was supported by a range of information about child health and development in leaflet form in the waiting area. The healthcare assistants at the practice also provided adult health checks for people aged between 40 and 75 who were not suffering from long term conditions. At the time of our inspection we were told that the practice had completed such health checks for 45% of the eligible patients in the practice population.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. We spoke with five patients on the day of our inspection including two members of the practice's patient participation group (PPG). PPGs are made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. All of the patients we spoke with reported that their GP and the nurses were courteous, considerate and compassionate. Patients also told us that all the reception staff were polite and had a pleasant manner with patients. This was borne out during our observations in the reception area when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk.

A notice asked patients to wait behind a line until called forward in order to respect the privacy of patients already talking to reception staff. Patients could be taken to an interview room to the side of the reception if they wanted to speak in private to a receptionist and there were notices displayed advising that this was available.

We reviewed 39 comment cards that had been collected from patients in advance of our visit. None of the comment cards indicated any negative or critical opinions and all of the cards reported wholly positive experiences of patients. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We looked at data from the 2014 National Patient Survey, carried out on behalf of the NHS and reported on the NHS Choices web-site. We noted that 86% or patients stated they would recommend the practice with 91% stating that they felt the practice was good or very good; these were among the higher range of ratings nationally and higher than the average for this Clinical Commissioning Group (CCG). 93% of patients reported that the reception staff were helpful. This was also higher than the national average. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (91%) and by their doctor (87%). This was similar to the national average.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male doctor.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey 2014 showed that, on average, 88% of patients felt the GP was good giving them enough time, good at listening to them and good at explaining test results to them. The survey showed that 91% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were higher than the average for both the local CCG area and for England in general. The corresponding figures for the nursing staff were also higher than average with 95% reporting that the nurses gave them enough time, listened to them and explained test results, whilst 88% felt the nurses involved them in care decisions.

Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of involvement. Some patients told us they felt in control. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. Further, a significant number of the 39 comment cards we reviewed reported that patients felt listened to.

We found that patients who were referred onwards to hospital or other services were involved in the process. We saw that patients could make a choice about where and when to receive follow-up treatment from hospital providers by the use of the 'choose and book' system.

The practice had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and

Are services caring?

treatment, particularly those that were recently bereaved. For example, staff we spoke with told us they were always made aware of the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

Furthermore, relatives of patients who had died were called by the practice in order to assess their emotional and support needs and to offer a referral to local counselling or bereavement support services. The practice also ran an in-house counselling service and patients were referred directly to this service by the GPs.

The care plans of people receiving end-of-life care and of those patients who were most at risk of unscheduled hospital admissions were discussed at weekly multi-disciplinary team meetings. This ensured that the practice could regularly and actively monitor the evolving needs of these groups of patients.

As we have reported above, the practice actively took steps to identify patients who were carers. This group of patients were provided with information about local services providing practical and emotional support and referrals to these services were actively managed by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. At the time of our inspection, the practice was in the process of leading the development of a strategic partnership with Northamptonshire Healthcare NHS Foundation Trust, three other GP practices in the area and the local Borough Council. This was in order to explore and further develop more integrated ways of providing local health and well-being services in the area although these discussions were still in their infancy.

We saw that the practice manager and one of the partners attended monthly meetings with the members of Clinical Commissioning Group (CCG) in order to consider and plan services to meet the needs of the local population. An outcome of this was that the practice provided some services for the local area, including those who were not registered at the practice. For example, the practice provided an ear-wax clinic, a skin condition clinic, a community vasectomy service and a dedicated lower urinary tract service for patients in the town and the CCG area.

The GPs at the practice had developed their own in-house specialism such as cardiology, rheumatology, minor surgery including vasectomy, many of which were of benefit to the wider community as well as the patients registered at the practice. For example, one of the GPs carried out occasional cardiology sessions in the cardiac suite at Kettering General Hospital.

The practice records management system was used to identify patients who might have specific needs This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care, children who were known to be at risk of harm or those patients who were caring for others.

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and a dedicated smoking cessation clinic.

The practice provided a service to four local care homes. In one home the practice carried out three ward rounds every week to meet the needs of people living there whilst another home was visited regularly and when required.

The practice had been particularly active in identifying those patients who were at risk of unplanned admission to hospital and who had tailored, individual care plans. The patients in this group were recorded on a register and the practice had a system in place for their care plans to be managed during weekly multi-disciplinary team (MDT) meetings. This enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including access to same-day appointments, clinical consultations on the telephone and access to the email address of the senior partner.

Patients we spoke with on the day of our visit said they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this prevailing view of the responsiveness of the practice.

Tackling inequity and promoting equality

The practice had a diverse workforce and had recognised the needs of different groups in the planning of its services. For example, the practice offered appointments out of scheduled times to patients with learning disabilities and enabled patients with complex needs or those who need an interpreter to book two consecutive appointments. This allowed more time to manage the consultation.

The premises and services had been adapted to meet the needs of people with disabilities. There was level access throughout, accessible toilets and a lift to enable patients in wheelchairs or who were less able to access the upper floor. We saw that the lift required two people to operate and so patients who attended alone were supported by reception staff to operate the lift or were offered an appointment in one of the ground floor rooms.

The practice had access to online and telephone translation services and double appointments were offered

Good

Are services responsive to people's needs?

(for example, to feedback?)

to patients who required an interpreter. Patients who were not permanent residents could access the service by either registering as a temporary resident or if their need for medical treatment was immediately necessary.

We noted that two of the GPs had received equal opportunities training provided by the East Midlands Deanery but other staff had not received any similar training.

Access to the service

The practice offered appointments that could be booked up to six weeks in advance for GPs and up to 12 weeks in advance for nurses. Additional appointments were also released in stages as well as on-the-day. Patients could book appointments over the telephone, in person or by registering to use an online facility governed by the practice's electronic patient record system.

Patients who wished to be seen in an emergency were offered an appointment slot towards the end of surgery opening times. The practice also offered telephone consultations where patients needed to speak with a GP but they could be called in to attend if their problem was subsequently found to require a face-to-face consultation. GPs carried out home visits to patients who were not able to get the practice.

The practice is located in an area which has a slightly higher than average proportion of working age people. In order to meet the needs of this group of patients the practice offered extended appointments outside of normal scheduled hours. These extended hours were between 6:30pm and 8pm on alternate Monday evenings and between 7:00am and 8am on alternate Wednesday mornings. The practice should note that these extended hours were not shown on the web-site and were not indicated in the practice information leaflet.

The 2014 National Patient Survey results showed that patient satisfaction with the practice's opening hours was among the top 25% in the country whilst patients' satisfaction with their experience of making an appointment was similar to the national average. On the day of our inspection, all five of the patients we spoke with said that they were happy with the appointment booking system. There were no concerns or critical comments about the appointment system on the 39 comment cards we received. Several patients commented positively about appointment availability. Patients could generally see the GP of their choice, including their choice of male or female GP although the patients we spoke with on the day of our inspection acknowledged that they sometimes had to wait a few days to do so.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was in line with recognised guidance and contractual obligations for GPs in England. There was information on the practice website, in leaflet form in the reception area and in a notice on the notice board advising patients of the complaints procedure. The complaints leaflet correctly referred patients to other NHS bodies where this was required and also provided advice about independent advocacy. All of the patients we spoke with said they had never had cause to complain told us they would know how to complain if necessary.

We noted that the practice took action to investigate complaints and discussed patients' concerns with the relevant staff member to whom the complaint referred. As with clinical audits and significant events, complaints and comments were discussed at the weekly MDT meetings so that the practice could learn from patients' experience.

We looked at the eight complaints received in the last 12 months and saw that these were satisfactorily handled and dealt with in a timely way. However, in the response letters sent by the practice we noted that there was not always a reference to the complainant's recourse to NHS England or the Ombudsman if they were dissatisfied with the outcome.

We looked at the list of complaints that had been provided to us for our inspection. This was the only list that the practice had and there was no means of formally logging or tracking complaints so that trends or concerns could be easily identified. The practice should collate complaints in the form of a log that enables such trends to be identified and the complaints and their outcomes to be monitored.

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 web-site carried their vision statement in the form of practice's statement of purpose they had submitted to the CQC as part of their registration. The principal stated aim was '…to work in partnership with patients and our staff to improve the health and wellbeing status of individuals and our local community'.

It was evident from our interviews with the management team, the GPs and the staff that the practice had an open and transparent leadership style. We saw that the whole team understood the practice's aims and adopted a philosophy of care that put outcomes for patients first.

As reported above, we found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice was in the process of leading the development of a strategic partnership with Northamptonshire Healthcare NHS Foundation Trust, three other GP practices in the area and the local Borough Council. The purpose of this as to explore and further develop more integrated ways of providing local health and well-being services in the local area although these discussions had not yet led to firm implementation plans.

Governance arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. The practice's multi-disciplinary team (MDT) management approach provided clear direction and structure. There were clearly identified lead roles for areas such as safeguarding, prescribing, proactive care (PAC), substance misuse, minor surgery and doctor training. These responsibilities were shared between the GP partners.

The practice had also identified areas of responsibility for other practice staff members. The nursing team had individually allocated areas of responsibility for areas such as wound care, asthma and diabetes. The practice administrative team also had lead areas of responsibility such as patient participation group (PPG) co-ordinator, new patient registration and MDT co-ordinator. In addition, one of the GPs and the practice manager represented the practice at the CCG meetings set up to consider the needs of healthcare service users in the locality.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The practice also actively used the findings of significant event analyses (SEA), clinical audits and referral peer reviews to understand and manage any risks to their service through the MDT system. Following each week's MDT meeting, the practice management team met to discuss the day-to-day running of the practice.

There were clear policies for each aspect of the practice's business accessible to staff through the practice computer system and these were subject of periodic review to ensure they were up-to-date. Staff were made aware of key policies during induction and could get access to clear instructions or protocols that set out how their work was to be performed.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of promoting patients health and wellbeing. The partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished.

Staff were clear about their own roles but not everyone was clear about other staff member's roles. We also found that there was some uncertainty among the staff members we spoke with about the frequency of all-staff meetings. Some staff thought that monthly protected learning time (PLT) sessions doubled as an all-staff meeting whilst others thought that all staff only met once every six months. There were no notes of such meetings so it was not clear how staff were involved in decision making across the practice. We noted however, that the practice kept staff apprised of decisions by way a 'team brief' issued three to four times each year through PLT sessions although there was no culture of consultation or challenge in which staff could contribute to the direction of the practice.

Are services well-led?

Good

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

We noted that none of the staff wore name badges with the exception of the lead nurse. Whilst this indicated a familiarity between staff members it indicated that patients would be unable to identify whom they might be dealing with.

Seeking and acting on feedback from patients, public and staff

We found that the practice engaged actively with its patient participation group (PPG). Such groups are made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. The practice manager was the designated lead role for the PPG at the practice which met every two months, reporting their activity through a newsletter distributed in reception. We looked at the profile of the PPG and saw that it was generally representative of the patient population with both men and women of varying ages with a consistent membership of around 12.

During our inspection we spoke with three members of the PPG, including the current chair person, who all told us that they felt the PPG was both supportive and challenging when required. We found evidence to support both of these positions. For example, we saw that the PPG had supported the practice in encouraging patients to use the checking in screen in reception and in providing clear information to patients about the practice's online services.

We also looked at the notes of the PPG meetings. We saw that the feedback the PPG had gained from patients about the location of the checking in screen had been acted on by the practice and had resulted in the screen being relocated.

Although the practice had a section on their web-site that sought comments from patients in the way of feedback about their experience, there was no suggestions box or comments box in the practice waiting area.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning through PLT sessions.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working.

The practice was registered with Leicester University and the East Midlands Deanery as a GP training practice. The practice regularly deploys registrars (experienced doctors training to become GPs) under the mentorship of one of the partners. We spoke with one of the registrars during our inspection who reported that the leadership structure and training method was supportive and effective in enabling registrars to learn and develop their expertise.