The Marine and Oakridge Partnership

Quality Report

Marine Surgery
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Southbourne
Bournemouth
BH6 3DB
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Date of inspection visit: 10/06/2015
Date of publication: 27/08/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Marine and Oakridge Partnership on 10 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, responsive, caring, well-led and effective services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

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, and addressed.
- Risks to patients were assessed and generally well managed. However not all infection control improvements identified had been actioned.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff received training appropriate to their roles and any further training needs had been identified and planned for.
- 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.
- 83% of respondents to a national patient survey said their overall experience of the practice was good.

Summary of findings

- Quality and outcome framework data for this practice in 2013/14 showed it had met 98.9% of the outcomes. This was higher than the national average of 94.2% for GP practices.

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

Action the provider SHOULD take to improve:

- Ensure actions required as a result of infection control audits are effectively managed.
- Produce an annual infection control statement.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Systems and processes to address risks were implemented consistently to ensure patients were kept safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Significant events were taken seriously and responded to in a timely manner. Patients' needs were assessed and care was planned and delivered in line with current guidance. This included assessing capacity and promoting good health.

Are services caring?

Good

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 and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. 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 quickly to issues raised. Complaints we looked at were investigated to a satisfactory conclusion for the patient.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their

Summary of findings

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 governance meetings. There were systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient participation group was contacted regularly for feedback. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice undertook audits and increased their identification of patients living with dementia in order to offer more care to the patient and any carers. Home visits were carried out for those patients too frail to attend the practice. Patients were given adequate time whenever they interacted with the practice and especially during their appointments. Patients with specific needs were offered longer appointments. GPs, practice nurses and community nurses visited older patients at home for their routine chronic disease management and monitoring. The practice premises were designed to facilitate easy access for patients who were frail or who had disabilities.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care

Families, children and young people

Good

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

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

Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 76% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 93% of people experiencing poor mental health had an agreed documented care plan in their records. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency 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.

Summary of findings

What people who use the service say

During our inspection we asked 14 patients to tell us about their experience of using the practice. Questions we asked included, practice opening hours, privacy and dignity, trust in the GP, cleanliness and whether they would recommend the practice to someone who moved to the area.

All but one of the14 patients we asked were very positive about their experiences of care and treatment at the practice. Positive comments included:

- Reception staff were helpful.
- They had confidence and trust in their GP.
- Their experience of using the practice was good.
- They would recommend the practice to someone new to the area.

The one negative comment was made about access to non-emergency appointments.

We also received 21 comment cards which were completed before the day of our inspection. Comments were positive and told us that the practice staff were efficient, caring and compassionate. Although two comments made reference to waiting times, both cards included positive feedback about staff. Another comment mentioned the wonderful care a GP gave to an older patient.

There was a virtual patient participation group (PPG) in place and this group were asked for their feedback by completing online surveys. Requests for volunteers to join the PPG were advertised through the practice website.

We also looked at the results of the GP patient survey published in January 2015. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey showed that the practice achieved better than average results for both the clinical commissioning group area and nationally in the following areas:

• 88% of respondents found it easy to get through to the practice by phone.

• 84% of respondents said the nurse was good at giving them enough time.

Areas for improvement

Action the service SHOULD take to improve

- Ensure actions required as a result of infection control audits are effectively managed.
- Produce an annual infection control statement.

The Marine and Oakridge Partnership

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 specialist advisor and a Practice Manager specialist advisor.

Background to The Marine and Oakridge Partnership

Marine and Oakridge Partnership is situated in Belle Vue Road, Southbourne, Bournemouth, Dorset.

The practice has an NHS general medical services contract to provide health services to approximately 10,200 patients.

Surgeries are held daily between the hours of 8.00am and 6.30pm from Tuesday to Friday and from 7.00am to 6.30pm on Monday.

The practice has opted out of providing out-of-hours services to its patients and refers them to South West Ambulance Service out-of-hours service via the 111 service.

The mix of patient's gender (male/female) is almost half and half. The practice has a higher number of patients aged over 65 years old (25.4%) when compared to the England average (16.7%).

The practice has a high number of patients who have a long term condition and a low number of patients who are unemployed when compared to the England average and is situated in an area of low deprivation.

The practice has six GP partners. In total there is one male and five female GPs who together work an equivalent of 3.75 full time workers.

The practice also has four practice nurses and two health care assistants. GPs and nursing staff are supported by a team of 13 reception staff and eight administration and secretarial staff who are managed by the practice manager and patient and personnel managers.

We carried out our inspection at the practice situated at;

Marine Surgery

29 Belle Vue Road

Southbourne

Bournemouth

BH6 3DB

Why we carried out this inspection

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

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.

Detailed findings

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 held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website and NHS National GP Patient Survey.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the patient and personnel manager. We also spoke with patients who used the practice. We reviewed comment cards and feedback where patients and members of the public shared their views and experiences of the practice before and during our visit.

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)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff told us about an instance when a patient became unwell and collapsed in the waiting room. Staff acted appropriately at the time and reported the incident as a significant event. As a result protocols were reviewed to ensure all staff were able to respond effectively in the future. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 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. We reviewed records of five significant events that had occurred during the last year and saw this system was followed and records confirmed these were discussed at clinical meetings. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the personnel and staff manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

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

A GP was the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who 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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy which had been reviewed in May 2015 and was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received a criminal records check via the Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and in the two medicine refrigerators. Access to these was only accessible to authorised staff. There were two other fridges at the practice. One was used for specimens (urine, stool and blood samples) and a spare fridge which was used during the flu season to store the large bulk of pre-ordered vaccines. The fridge thermometers were regularly calibrated and evidence of this was seen. 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 the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. We checked medicines in both fridges and all were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There was a box in the drug cupboard for any returned medicines and these were then taken on a regular basis to the pharmacy.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both Patient Specific Directions (PSDs) and Patient Group Directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. We also saw that PSDs were scanned and then filed into the relevant patient record.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. 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. The policy included information about hand hygiene, sharps handling, safe disposal of clinical waste, cleaning and maintenance of equipment and uniform dress code.

Personal protective equipment was available and included 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. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, sanitising hand gel and paper hand towel dispensers were available in treatment and consulting rooms. Sharps boxes were provided and were positioned out of the reach of small children. Clinical waste was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed.

New staff received a limited amount of induction training about infection control. Areas covered included hand hygiene and personal protective equipment. The practice had a lead for infection control. This member of staff had not undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training.

We saw evidence that an infection control audit was carried out in January 2015 and June 2015 and improvements identified but there was no evidence to confirm remedial action had been undertaken. We asked for the practice's annual infection control statement and were told this had not been written. We saw records that confirmed the practice carried out a legionella risk assessment in April 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. A schedule of testing was in place and all relevant equipment required to run the service was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Equipment tested included fire extinguishers, the central heating boiler and stair lift which were maintained and tested regularly. Both the fire alarm and intruder alarms were tested every six months. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was February 2015. Mains electricity wiring was tested in July 2014 and the gas supply was tested in January 2015.

We saw evidence of servicing and calibration of relevant medical equipment was carried out in November 2014. Equipment tested included weighing scales, spirometers, blood pressure measuring devices and the defibrillator. A second certificate was seen which identified that the medicines/vaccine fridges had been serviced and tested in March 2015. We also saw evidence to confirm the oxygen cylinder had been serviced and tested in January 2015.

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

Good

Are services safe?

professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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 that enough staff were on duty. There was also 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 patient and personnel manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and a GP partner was identified as the health and safety representative. Day to day responsibility was also assumed by the practice manager. Identified risks were assessed, rated and mitigating actions recorded to reduce and manage the risk. This was evidenced in a risk assessment undertaken after a member of staff disclosed their pregnancy.

We also saw a health and safety folder which contained various health and safety related policies.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and certificates showed that all staff had received training in basic life support during the last 12 months. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Staff knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of this location. Medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, flood, fire, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the patient electronic record system company were available so that staff could make alternative arrangements with them if systems failed. The practice had carried out a fire risk assessment in March 2014 which included actions required to maintain fire safety. Fire safety checks were carried out with the exception of monthly checks of the emergency lighting.

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 what would happen if more than one GP were to be off at one time and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw 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 GPs told us they lead in specialist clinical areas such as dermatology 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.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices.

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 higher than average with referral rates to secondary and other community care services for all conditions when compared with the national average. We were told that this was due to the age of patients registered with the practice.

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

Management, monitoring and improving outcomes for people

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

The practice showed us two audits that had been undertaken in the last year. Both of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. One audit was carried out as a result of a medicine alert stating Diclofenac sodium should not be prescribed to patients with vascular disease due to increased risk of cardiovascular events. A search was made of patients who were at risk and prescribing was changed to remove the risk of complications. A second audit was carried out three months later which confirmed that no patients who were at risk were prescribed this medicine.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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 antibiotics to determine whether they were necessary.

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. The practice also met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease) and 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.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

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

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that on the whole staff were up to date with attending mandatory courses such as annual basic life support.

We noted a good skill mix among the GPs with one having an additional diploma in dermatology and another in sexual health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs and action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a GP was booked to attend an electronic repeat dispensing update, a health care assistant had attended Vitamin B12 injection, phlebotomy and anaphylaxis training and a senior nurse had recently attended a diabetes course at the local hospital.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service. These documents and results were received either electronically, by fax, email or post. In each case they were entered onto the patient record; directly when received electronically or scanned and attached if received by other means.

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. Staff we spoke with confirmed this. All communications were entered onto the clinical system and electronically "work flowed" to the relevant clinician, who then determined what the appropriate course of action was and then either dealt with it themselves or communicated it back to reception staff to arrange follow up appointments or take other appropriate action.

The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

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 that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure 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 by district nurses,

Good

Are services effective?

(for example, treatment is effective)

social workers, palliative care nurses and decisions about care planning were documented in a shared care record. 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 3885 (68%) 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 that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The GP printed out a summary and handed it to the patient in a sealed envelope. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called SytstmOne to coordinate, document and manage patient 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 that action had been taken to address any shortcomings identified.

Consent to care and treatment

We reviewed data from the national GP patient survey, published in January 2015; which showed the practice was rated below the local and national patient satisfaction average by patients who were asked how good they felt the GP was at involving them in decisions about their care and treatment. Of the patients asked, 73% said they felt the GP was good.

We found that staff were aware of the Mental Capacity Act 2005 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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 contained 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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice protocol 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. We were shown an audit that confirmed the consent process for minor surgery had being followed in 93.5% of cases.

Health promotion and prevention

We saw a range of health promotion information available at the practice and on its website. This information included information about preventative health care services being offered. For example, cervical smears and vaccinations. Information on the practice website also included information about how patients could self-manage their condition.

It was practice policy to offer a health check 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. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 67% of patients in this age group had received

Good

Are services effective?

(for example, treatment is effective)

a check. A GP showed us how patients were followed up within two weeks if they had risk factors for specific diseases 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 all 42 patients were offered an annual physical health check. Practice records showed 76% had received a check up in the last 12 months.

The practice had also identified the smoking status of 96% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 423.

Similar mechanisms of identifying 'at risk' groups were used for patients who were clinically obese and those receiving end of life care. These groups were offered further support in line with their needs. The practice identified 780 patients who were clinically obese and we were told they were all offered support to lose weight. The practice was unable to provide any more details about specific support other than records of three patients being offered exercise and weight management advice, five had been referred to a dietician and two were referred to a weight management programme.

The practice's performance for cervical smear uptake was 84%, which was better than the national average of 82%. There was a protocol to offer two written reminders for patients who did not attend for screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above the national average for under two year olds at 97% and five year olds at 97% and again there was a clear policy for following up non-attenders.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the results of the most recent GP patient survey, published in January 2015. Results showed the practice was rated as being in line with the national patient satisfaction averages by patients who were asked about how they were treated by GPs and nurses. Of the patients asked, 80% said they felt GPs treated them with care and concern and 75% also said they felt nurses treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and almost all were positive about the service they experienced. Patients said they felt the practice staff were polite, caring and kind. They said staff treated them with dignity and respect. We also asked 14 patients on the day of our inspection and all 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. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We saw that staff were careful 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.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The patient and personnel manager told us their role would be to investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed how patients felt they were treated. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 81% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87%.
- 79% said the GP gave them enough time compared to the CCG average of 88% and national average of 85%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 92%

Patients we asked on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Staff demonstrated an understanding of the impact a patient's condition/treatment could have on those close to them and were aware of the need to support relatives as well as patients. There was a system for assessing the support needs of carers. The new patient questionnaire asked if the patient was a carer for someone with a medical condition and if so who and how they were related.

GPs had their own patient lists that meant they had a closer relationship with patients which appeared to work well at times of crisis. Staff told us GPs made contact with the bereaved relative/spouse when they were made aware of the person's death.

Information and links to counselling support was available on the practice website which included, NHS Counselling, Mental Health, Samaritans, and Cruse Bereavement counselling services. There was also a counsellor based at the practice who saw patients referred by GPs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Tackling inequality and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had disability and learning disability protocols and staff received training via on line learning. We observed staff acting in an appropriate way to every patient they engaged with.

The practice was accessible to disabled patients who required level access. The practice had a wheelchair available for patients who found it difficult to manoeuvre around the practice and also a hearing loop was available for patients who had hearing impairments.

The practice was situated over two floors with most services for patients on the ground floor. A stair lift was available on request. This made movement around the practice easier and helped to maintain patients' independence. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Wheelchair accessible toilet facilities were available for all patients attending the practice and there were baby changing facilities. The practice was spacious and uncluttered throughout. Treatment rooms were large which made them accessible to wheelchairs and prams.

The practice had a population of 98% English speaking patients. Practice staff had access to interpreting services, via language line and there were facilities for patients to translate the practice website into 75 different languages.

Access to the service

Appointments were available from 8am to 6.30 pm from Tuesday to Friday and from 7.00am to 6.30pm on Monday. Appointments could be booked up to four weeks in advance.

Comprehensive information was available to patients about appointments in the practice leaflet and on its website. Information included how to arrange urgent appointments and home visits and how to book and cancel appointments, how to book a telephone consultation and how to book a same day face-face emergency appointment. Patients could also view a summary of their medical record, view test results and complete a health questionnaire on-line.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were satisfied with the appointments system and ease of getting through to the practice by phone. We looked at the results of the most recent GP patient survey, published in January 2015. Of the patients asked, 85% said their last appointment was convenient and 81% said they found it easy to get through to the practice by phone. The latter percentage was higher than national patient satisfaction average of 72%.

One of the GPs held a weekly specialist minor surgery clinic to treat patients who had a skin conditions and carried out excisions and biopsies of skin lesions, moles, cysts, and small lumps and bumps. Access to the clinic was by the choose and book system which the patients GP initiated. Information about this was available on the practice website and the practice area of the NHS Choices website.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy had been reviewed in May 2014 and was in line with recognised guidance and contractual obligations for GPs in England.

There was a designated responsible person who handled complaints in the practice. How to complain information was available on the practice website; in the practice leaflet; and on request in reception. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

We were shown a file which contained 12 clinical and 16 general complaints received in the last 12 months and found that full details of complaints and resulting investigations were kept. We reviewed these had been dealt with appropriately, investigated and the complaint responded to in a timely manner. For example, a patient complained about a GP who had failed to diagnose an infection. We saw that an apology was given and information about the GPs learning was documented to ensure a repeat did not happen. Another example seen included a complaint from a female patient who was not offered a chaperone when receiving an intimate

Good

Are services responsive to people's needs?

(for example, to feedback?)

examination. We saw records to confirm the practice had apologised to the patient how the protocol for chaperones had been changed to include more information for patients and a process for GPs to ask patients before carrying out intimate examinations.

We saw information for patients about advocacy services and how to complain in the waiting area, the patient leaflet and on the practice website.

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. These values were displayed on the practice website. The practice vision and values included combining the traditional values of general practice with evidence based modern medicine.

We spoke with staff who all knew and understood the vision and values and knew what their responsibilities were in relation to these.

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 many of these policies and procedures and were told that staff had read the policy although there was nothing that evidenced this. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it in 2013/14 they had met 98.9% of the outcomes. This was higher than the national average for GP practices, the average being 94.2%. 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 on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice was registered with The Information Commissioners Office, as required by The Data Protection Act, and also had adequate employer's liability insurance in place.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the partner GP was the lead for safeguarding.

Staff were all clear about their own roles and responsibilities. Staff told us that there was an open culture within the practice and they felt valued, well supported and knew who to go to in the practice with any concerns.

The patient and personnel manager was responsible for human resource policies and procedures.

We reviewed a number of policies which included the practice training policy, disciplinary procedure, grievance procedure, sickness and absence policy, confidentiality policy, chaperone policy, data protection policy and consent policy.

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

We looked at the results of the most recent GP patient survey, published in January 2015 and 75% of patients who responded said they would recommend the practice to someone new to the area. This was in line with the national average.

All the staff spoken with told us they felt engaged with the practice. They also had access to both the Practice Manager and the Patient and Personnel Manager and told us that they were able to express ideas and concerns. Staff also stated that communication from the GPs was also very effective and they felt able to discuss matters with them.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

The practice had a "virtual" patient participation group (PPG) which communicated by email and consisted of 13 members. We saw a stated intention within the 2014-2015 report, to move the group towards a more "face to face" group and it is hoped that this will be achieved by the efforts of a newly recruited member of staff.

Patient surveys were carried out face to face, by post, online, at flu clinics and at mother and baby clinics. Feedback from a previous survey highlighted issues and concerns with the practice appointment system. These were discussed and changes were implemented as a result of the feedback. Initially changes were made by the adoption of "Doctor First" but then they system was later changed and refined as a result of subsequent feedback.

Other changes made as a result of feedback included the increasing of call handling facilities by the purchase of more telephone lines.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

Annual appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

There were arrangements in place to manage staff performance. Staff told us that they could contribute their views to the running of the practice and that they felt they worked well together as part of the practice team to ensure they continued to deliver good quality care.

The practice took account of complaints to improve the service and significant events were discussed and learnt from through regular quality meetings.