Newbridge Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 Newbridge Surgery on 6 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, safe, effective, caring, responsive and well-led services. It was found to be good for providing 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, appropriately reviewed and addressed.
- Most risks to patients were assessed and well managed. However, the risk of not having oxygen in the practice for use during a medical emergency had not been risk assessed.
- 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 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

- Formally assess the risk of not having oxygen in the practice for use during a medical emergency. This should include how patients will receive appropriate care and treatment in acute asthma attacks and other causes of hypoxia (insufficient oxygen in the blood and tissues).

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Most risks to patients were assessed and well managed. However, the risk of not having oxygen in the practice for use during a medical emergency had not been risk assessed. Plans were not in place to demonstrate how patients would receive the appropriate care and treatment in acute asthma attacks and other causes of hypoxia (insufficient oxygen in the blood and tissues).

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

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a

Summary of findings

named GP and that there was continuity of care. The daily sit and wait drop in clinic meant that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

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 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 and identify risk. Clinical audits had been carried out but did not always identify what changes needed to be made to improve outcomes for patients. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. They had a range of enhanced services, for example, end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. A representative from a local residential home for older people told us that the GPs at Newbridge surgery were in the process of putting care plans in place for the patients who lived there and that all the patients had a named GP. They told us that all these patients had received an annual health review in the last 12 months

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. Structured annual reviews to check that the health and medication needs of patients with long term conditions were met and had been carried out. 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 who were at risk. For example, children and young people who had a high number of accident and emergency (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.

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

Summary of findings

working age population, those recently retired and students had been identified and the practice offered services 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 reflected 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 carers and those with a learning disability. The practice had 27 patients on its learning disability register and 26 of these patients had received an annual health review in the last 12 months. It offered longer appointments for people with a learning disability. The practice provided care to three hostels for homeless women and a hostel for people recovering from alcohol misuse.

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). Eighty-four per cent of people with a diagnosis of dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Five of the six patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. One patient was less complimentary about the care they received but the practice told us they would investigate their concerns. We reviewed the 14 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that all of the comments were positive. Patients told us the staff were always helpful, professional, caring, friendly and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy.

The results from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 92% of patients said that their overall experience of the practice was good or very good and that 94% of patients would recommend the practice to someone new to the area. This was significantly above the Clinical Commissioning Group (CCG) regional average of 84% and 72% respectively.

Areas for improvement

Action the service SHOULD take to improve

The provider should formally assess the risk of not having oxygen in the practice for use during a medical emergency. This should include how patients will receive appropriate care and treatment in acute asthma attacks and other causes of hypoxia (insufficient oxygen in the blood and tissues).

Newbridge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Newbridge Surgery

Newbridge Surgery is located on the outskirts of Wolverhampton close to Tettenhall Village. It was built in the 1920s and was formally a residential home. It is a large, two storey, Edwardian building and was converted into a GP practice in 1992. Three additional consulting rooms were added to the rear of the practice in March 2010. Parking is to the rear of premises.

A team of three GPs; a GP registrar (GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine); a practice nurse and a health care support worker; a practice manager; seven receptionists and three administrative staff provide care and treatment for approximately 4400 patients. There are one male and two female GPs at the practice. The practice is a training practice for GP registrars to gain experience and higher qualifications in general practice and family medicine. The practice does not routinely provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen by Prime Care out of hours service when the practice is closed.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with the chairperson from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We also spoke with a community matron and representatives from a home for people with learning disabilities, a residential home and a hospice where the practice provides care and treatment. We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 6 May 2015 at the practice. During our inspection we spoke with a GP partner; a GP registrar; a nurse and a health care support worker; two receptionists; the practice manager and six patients. We observed how patients were cared for. We reviewed 14 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that the nursing staff had raised concerns when the temperature of the vaccine fridge exceeded the manufacturers' guidelines. We saw that appropriate action had been taken and training needs identified.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. 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 saw that significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at practice meetings and they told us they felt encouraged to do so.

Staff used significant event forms and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor significant events. We tracked two incidents and saw records were completed in a comprehensive and timely manner. For example, when it was identified that not all staff were aware of how to download data from the vaccine fridge temperature data logger, training had been provided.

National patient safety alerts were disseminated electronically to practice staff in line with their practice safety alert policy. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, a nurse told us about an alert they had received regarding the use of diabetic blood testing strips. They told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. The GP partners also discussed these at their weekly partners meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding children and vulnerable adults. The GP registrar told us that safeguarding training was treated as a priority when they first joined the practice. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. 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 and out of normal hours. Contact details were readily available in each treatment and consultation room and in the reception area where reception staff worked.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. They had the necessary training to enable them to fulfil this role. All the staff we spoke with were aware who the lead was and who to speak within the practice if they had a safeguarding concern. We spoke with the GP safeguarding lead who described to us the system in place for reviewing patients who frequently attended the accident and emergency (A&E) department. They told us that A&E attendances were reviewed on a weekly basis by the GPs and practice manager. When children or vulnerable adults were identified as frequent A&E attenders, their care was discussed at the weekly GP meeting and patients followed up if a need was identified.

There was a system to highlight vulnerable patients in 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 a chaperone policy in place at the practice for staff to refer to for support. It was also available in the

practice folder for patients to refer to. Signs informing patients of their right to have a chaperone present during an intimate examination were clearly displayed in consultation and treatment rooms and in the reception area. 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 the health care assistant, 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 and the actions to take if they had any concerns.

Medicines management

We checked medicines stored in the treatment room and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. Nursing staff had provided 'flu vaccinations at local care homes. They accurately described the processes they followed to maintain the cold chain when taking vaccines to the care homes. However, this process was not recorded in the practice's vaccine storage policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice manager had a system in place to check the expiry dates of the medicines kept in the GP bags used for home visits.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurse had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were stored securely in a locked cupboard. We saw that GP prescription pads used for home visits were handled in accordance with national guidance to track them through the practice.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training about infection control specific to their role and received annual updates. We saw evidence that an annual infection control visit was undertaken using the GP infection prevention and control audit tool. We saw that overtime the practice had increased its general practice rating from 84% to 98% and its minor surgery score from 86% to 98%.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they used these in order to comply with the practice's infection control policy. There was a policy for needle stick injuries and staff knew what to do if this occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that appropriate staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that a legionella risk assessment had been completed in January 2013 to protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment

maintenance logs and other records that confirmed this. We saw records that demonstrated all portable electrical equipment had been tested in February 2015 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in February 2015 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, it did not include the need for staff to explain gaps in their employment history.

The practice manager 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.

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 practice manager showed us records that demonstrated staffing levels were sufficient to meet the demands of the service.

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. We saw records that demonstrated that annual and monthly checks of the building had been carried out. This included a fire risk assessment and annual fire drills for staff; gas safety checks; emergency lighting tests and an asbestos management risk assessment. The practice also had a health and safety policy. We saw that several risk assessments had been carried out. For example, lone working, handling clinical waste and body fluid spillages.

Identified risks were included on a risk log. Each risk was assessed and rated and action plans put in place to reduce and manage the risk. We saw that the practice had participated in an NHS initiative for health research to monitor patient safety using an approved toolkit. This monitored performance in several domains such as communication, workforce, leadership, teamwork, safety systems and learning. We saw that the practice had performed higher than average across all these domains.

The practice had identified the top 2% most vulnerable patients in their practice population. To support these patients, the practice worked closely with attached staff such as district nurses, palliative care nurses and community matrons. We saw minutes that demonstrated that multidisciplinary meetings were held on a three monthly basis to support and manage risks to these vulnerable patients. We spoke with the community matron and a palliative care community nurse prior to our inspection. They both told us the communication and engagement of the GPs at the practice was excellent.

Arrangements to deal with emergencies and major incidents

Records showed that all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). Airway management equipment was available for adults and children. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly. However, oxygen was not kept at the practice. Oxygen is used in the treatment of medical emergencies such as acute asthma attacks and other causes of hypoxia (insufficient oxygen in the blood and tissues). A risk assessment demonstrating why this decision had been made had not been completed. An action plan providing guidance for staff in the management of patients during a medical emergency when oxygen was unavailable was not in place. A GP told us that they had never needed to use oxygen in a medical emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low

Good

Are services safe?

blood sugar. 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 loss of information technology, GP sickness and the loss of domestic services. We saw that the business continuity plan included plans to manage these situations and emergency contact numbers were readily available at the back of the plan.

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

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. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GP registrar told us that the GPs had provided training in the use of NICE guidelines in areas such as the two week wait referral process for patients with possible cancers and the prescribing of medicines used for the treatment of high cholesterol.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions. We saw training certificates which demonstrated that the practice nurse had received the additional training they required to carry out this role. For example, the review of patients with long term conditions such as asthma and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The GP we spoke with used national standards for the referral of patients with suspected cancers so that patients were referred and seen within two weeks. The practice used the Choose and Book system to refer patients for hospital appointments. (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).

Discrimination was avoided when making care and treatment decisions. The culture in the practice was that patients were cared for and treated based on need.

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 to support the practice in planning the services it provided for patients.

The practice had a system in place for carrying out clinical audits. The practice showed us three clinical audits that had been carried out recently. For example, the practice had carried out an audit of patient deaths. Two aims of the audit were to review if terminally ill patients who were receiving palliative care died in their preferred place of care and if terminally ill patients received anticipatory medicines. Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops symptoms and is used in areas such as the management of pain. The audit demonstrated that 17 out of 20 of terminally ill patients died at their preferred choice of care. It also demonstrated that 11 out 20 of terminally ill patients had anticipatory medicines in place. The audit identified the need for GPs to be more proactive in ensuring that patients near the end of their life have anticipatory medicines in place. A follow up audit had not been carried as yet to monitor the effectiveness of this. Other examples included audits of the insertion of coils (a contraceptive devise) and minor surgery procedures.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. 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 such as diabetes. The results are published annually. For example, 95% of patients with diabetes and 92% of patients with COPD had an annual medication review. The practice met all the minimum standards for QOF in long term conditions and had achieved 99.2% of QOF points for 2013-2014 which was above the national average of 94.2%. A long term condition is a condition that can be controlled but not cured.

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

Good

Are services effective?

(for example, treatment is effective)

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 medicines alerts when the GP was prescribing medicines.

The practice followed the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw that there were 27 patients currently on the palliative care register.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all the 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 two GPs having additional diplomas in obstetrics and gynaecology, and one GP with a diploma in children's health. All the GPs were up to date with their yearly continuing professional development requirements and had all been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The practice nurse we spoke with told us that they had been fully supported to attend training appropriate to their role and their professional development. As the practice was a training practice, doctors who were training to be qualified GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the GP registrar we spoke with.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, the administration of childhood immunisations, ear irrigation and cervical smears. The practice nurse also carried out extended roles such as the management of COPD and asthma and was able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage 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 both electronically and by post. We saw that there was a system in place for recording when blood tests and smears were sent to the pathology department and when the results were received by the practice. Staff described to us the processes they followed to chase up any outstanding results. All the staff we spoke with were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required.

The practice was commissioned for the new enhanced service of reducing avoidable hospital admissions 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 there was a system in place for identifying, reviewing and following up patients as required.

The practice held multidisciplinary team meetings on a three monthly basis to discuss the needs of complex patients. For example, those with end of life care needs or patients with multiple long term conditions. These meetings were attended by district nurses, community matrons and palliative care nurses. We spoke with a community matron and a community palliative care nurse prior to our inspection. They told us that 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, the practice completed electronic forms which they forwarded to the local GP out-of-hours provider, Prime Care. This enabled patient data to be shared in a secure and timely manner. The practice used the electronic referral system,

Good

Are services effective?

(for example, treatment is effective)

Choose and Book, to refer patients to other services. 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.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. A practice nurse described to us the process they followed when considering the best interest decisions made in giving a patient with dementia a 'flu vaccination.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies when providing care and treatment to children. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, formal written consent was obtained for the insertion of coils. Informed consent was obtained for immunisations and joint injections and recorded in the patients' records.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant 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 had several 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 26 out of 27 had received a health review in the last 12 months. Forty-four out of 47 patients experiencing poor mental health had received a health review in the previous 12 months.

The practice had identified the smoking status of patients over the age of 16 and had actively offered nurse-led smoking cessation clinics to these patients. We saw data that demonstrated the practice had some success in supporting patients to stop smoking. We saw that seven out of 22 (32%) patients had stopped smoking in the last 12 months.

The practice's performance for cervical smear uptake was 80%, which was in line with the national target. There was a policy to offer telephone reminders for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data showed that for 2013 – 2014 the practice's performance for childhood immunisations was above average for the CCG. We also saw data that demonstrated 77 % of patients over 65 years of age, 67% of patients under 65 years and 'at risk' and 76% of pregnant women had received the 'flu vaccination in 2014-2015.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey carried out during January-March 2014 and July-September 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 92% of respondents said that their overall experience was good or very good and 94% of respondents would recommend the practice to someone new in the area. These results were significantly above the regional Clinical Commissioning Group (CCG) average of 84% and 72% respectively.

The practice was above the CCG regional average for its satisfaction scores on consultations with doctors and nurses. For example, 88% of respondents said the GP, and 95% said the nurse was good at listening to them. This was above the CCG regional average of 83% and 79% respectively. We looked at the results of the Family and Friends test for April 2015 which asked patients whether they would recommend their GP practice to their friends and family. We saw that 100% of respondents said they would be likely or extremely likely to recommend this practice.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and the staff were always helpful, professional, caring and friendly. They said staff treated them with dignity and respect and listened and responded to their needs.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located behind the reception desk which was shielded by glass partitions which helped keep patient information private. The waiting room was in a separate room away from the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw there was a sign on display informing patients to wait until the reception desk was free before they approached it. If a patient wished to speak to a receptionist in private, receptionists told us they took patients to a private room.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. 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 practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area and on the practice's website stating their zero tolerance for abusive behaviour. This was helpful to receptionists in helping them to diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey carried out during January-March 2014 and July-September 2014 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the survey showed 82% of practice respondents said the GP was good at involving them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were above the regional CCG average of 72% and 79% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

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

Staff told us that translation services were available for patients who did not have English as a first language. Information was available on the practice website.

Prior to our inspection, we spoke with a community matron who worked with the practice to provide care and support to patients with long term conditions and terminally ill patients. They told us that the practice was proactive in identifying and communicating concerns about these patients. They told us that they worked with the practice to involve these patients in decisions about their care. Structured multi-disciplinary meetings were held at the practice on a three monthly basis to discuss the care of these patients. We saw minutes from meetings that confirmed this.

We spoke with a representative from a residential home for older people. They told us that the GPs at Newbridge surgery were in the process of putting care plans in place for the patients who lived there and that all the patients had a named GP. They told us that all these patients had received an annual health review in the last 12 months. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNACPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. People are able to make the decision that they do not wish receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands.

The manager from a residential home for people with a learning disability confirmed that all the patients registered with the practice and who lived at the home had a care plan in place. They told us they also had a health action plan that had been agreed with the patient. This was available to patients in an easy read format so that they understood it. A health action plan is a plan for young people or adults with learning disabilities that outlines their health needs and the support they need to stay healthy.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 86% of respondents to the national patient survey carried out during January-March 2014 and July-September 2014 said the last GP they saw or spoke with was good at treating them with care and concern. This was above the regional average of 77%. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. For example, support groups for carers and patients with dementia. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. To do this, carers were offered the seasonal 'flu vaccination.

The practice had a system in place to support patients known to them who had suffered a recent bereavement. We spoke with a GP who told us that bereavement support was based on a risk basis. Patients were provided with a pack informing what to do when someone dies. If appropriate, the GP told us they referred patients either to their in-house counsellors or CRUSE bereavement care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Local Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The senior GP partner told us that they attended monthly CCG meetings and had been involved in CCG pilots to respond to the needs of patients. For example, the implementation of standardised care pathways and referral forms to other services.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Prior to our inspection, we spoke with the chairperson of the PPG. They told us of several improvements the PPG had asked the practice to make. For example, to remove unnecessary posters from the walls in the reception area and to introduce a system of recording when patient tests were sent and received back from the hospital pathology department. The chairperson of the PPG told us that the practice responded immediately to their concerns and appropriate changes had been made.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning for all staff and we saw training certificates that confirmed this. Staff we spoke with confirmed that they had completed the equality and diversity training.

The practice recognised the needs of different population groups in the planning of its services. The practice was situated on the ground and first floors of the building with services for patients provided on the ground floor only. 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. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included two disabled parking spaces; step free access to the front door of the practice; disabled toilets and a hearing loop for patients with a hearing impairment. There was a door bell at the front door for patients in wheelchairs to ring to inform the reception staff to open the door and assist them into the practice.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care. Information informing patients of this was on the practice's website and in the practice information leaflet

The practice provided care and support to several house bound elderly patients and patients living in care homes for the elderly and residential homes for patients with learning difficulties. Patients over 75 years of age had a named GP to ensure continuity of care. Patients with learning disabilities were provided with annual health reviews at the practice and a health action plan. This was available to patients in an easy read format so that they understood it. A health action plan is a plan for young people or adults with learning disabilities that outlines their health needs and the support they need to stay healthy. If their learning disability prevented them from accessing the practice, a GP home visit was provided. The manager from a residential home for people with a learning disability confirmed that all the patients registered with the practice and who lived at the home had a care plan and a health action plan in place.

The practice provided care to three hostels for homeless women and a hostel for people recovering from alcohol misuse. They also provided care to two children's homes in the area and a number of foster families. The practice had a policy to accept any patient who lived within their practice boundary irrespective of culture, religion or sexual preference.

Access to the service

The practice was open Monday to Friday 8am until 6.30pm except for Thursdays when it was open 8am until 5.30pm. Extended opening hours were also available from 7am on Wednesdays which were particularly helpful for working age patients and school children. Patients could pre-book appointments throughout the day either over the telephone, face to face or on line through the practice's

Good

Are services responsive to people's needs?

(for example, to feedback?)

website. In addition, the practice held a sit and wait clinic which was available from 8.50am until 11am each weekday morning. When the practice was closed patients were directed to Prime Care out of hours service. Patients could book appointments up to 12 months in advance. We spoke with one patient on the day of our inspection who told us they had booked an appointment three months in advance. On the day appointments were also available and GPs provided telephone consultations if appropriate to do so. The open access service was particularly helpful for people living in the four hostels as it provided daily access to health care and treatment for this transient population.

Information from the national patient survey showed that 98% of respondents found it easy to get through on the phone and 89% of respondents described their experience of making an appointment as good or very good. These results were above the local CCG average of 75% and 73% respectfully. The practice's own patient survey, patients we spoke with on the day of our inspection and the comment cards we reviewed also supported this view. Many patients commented on the usefulness of the sit and wait drop in clinic.

Staff we spoke with told us that children were always provided with an on the day appointment if required. We spoke with a parent of a young child with an on-going medical condition on the day of our inspection. They told us how much they valued the flexibility of the sit and wait drop in clinic. Patients with a learning disability were offered longer appointments to ensure they were given adequate time to discuss and understand their treatment.

Listening and learning from concerns and complaints

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

We saw that there was a practice leaflet informing patients how to complain both to the practice and to the other authorities such as the Care Quality Commission, NHS England and the Ombudsman. Information was also on display in the reception area and on the practice's website. Patients we spoke with were not aware of the process to follow if they wished to make a complaint however they said they would speak with the receptionist first. We spoke with two receptionists on the day of our inspection who were able to accurately describe to us the procedures they would follow if a patient wished to make a complaint.

We looked at the one complaint received in the last 12 months and found it has been responded to and dealt with in a timely manner and that there was openness and transparency when dealing with it. We saw practice meeting minutes that demonstrated that complaints were a regular agenda item and that learning from them was shared with staff so they were able to learn and contribute to any improvement action that might have been required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose which was available on the practice's website and in the practice's entrance hall. We found details of the vision and practice values were part of the practice's strategy and annual business plan. The practice vision stated, 'Newbridge Surgery aims to provide our registered patients with high quality, safe, personal health care within the framework of the NHS, and to seek continuous improvement on the health status of the practice population overall. We aim to achieve this by developing and maintaining a happy sound practice which is responsive to people's needs and which reflects, whenever possible, the latest advances in Primary Health Care.'

We saw that this was underpinned by their values which included providing personalised patient care; focusing on prevention of disease by promoting health and wellbeing; working in partnership with patients, their families, carers and other agencies; acting with integrity and confidentiality and treating all patients and staff with dignity, respect and honesty in an environment that is accessible, safe and friendly. A patient charter was also available on the practice's website and in the patient information leaflet. This outlined patients' rights and responsibilities and details of the service that patients could expect to receive.

We spoke with seven members of staff and they all knew and understood the vision and values and 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 practice's intranet. We looked at 18 of these policies and procedures. Staff told us that there was a system in place to ensure that when changes were made to polices staff were made of aware of this. They told us that they received an email alert and that the practice manager recorded their response when they confirmed they had read the policy. All of the 18 policies and procedures we looked at had been reviewed on a two yearly basis and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing higher than national standards with a practice value of 99.2%. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about the monthly educational forum,' Practice makes Perfect', they attended for practice nurses to share ideas and learning with neighbouring GP practices. They told us that they found this very supportive and enabled them to keep up to date with changes in general practice.

The practice had an on going programme of clinical audits which it used to monitor quality. For example, the practice had carried out annual audits of their minor surgery procedures. The audits showed there had been a slight increase from 73% to 74% of patients who reported improvements since receiving the surgery. However, the audits did not identify how improvements for patient outcomes could be made.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, for example, lone working, handling clinical waste and body fluid spillages. Each risk was assessed and rated and action plans put in place to reduce and manage the risk. However, a risk assessment had not been carried out to demonstrate how staff would manage the risk to patients in the event of a medical emergency when the practice did not have access to oxygen. We saw that the practice had participated in an NHS initiative for health research to monitor patient safety using an approved toolkit. This monitored performance in several domains such as communication, workforce, leadership, teamwork, safety systems and learning. We saw that the practice had performed higher than average across all these domains.

Are services well-led?

Good

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

Leadership, openness and transparency

Practice meetings were held three monthly for all staff and the GP partners and practice manager held weekly business and governance meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. The practice had a whistle blowing policy which was available to all staff to access by the practice intranet. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and staff induction procedures which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints and their patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We looked at the action plan that had been put in place following the PPG patient survey. We saw that the practice and PPG had identified three priority areas. These included receptionists to inform patients when the GP was running behind schedule, an onsite pharmacy to be available for patients and access to the building to be improved by automatic entrance doors. Receptionists told us they now informed patients when the GPs were behind schedule and we saw that an independent pharmacy was located in the practice. Automatic doors were an on going item for discussion however the chairperson of the PPG told us that the practice were planning on putting these in place.

The practice had an active PPG which consisted of 42 patients, 12 male and 30 female. The ages of these patients ranged from 25 years to over 75 years of age and covered various ethnic groups. The PPG had carried out patient surveys and meet two to three monthly. Prior to our inspection, we spoke with the chairperson of the PPG. They told us of several improvements the PPG had asked the practice to make. For example, to introduce a system of recording when patient tests were sent and received back from the hospital pathology department. The chairperson of the PPG told us that the practice responded immediately to their concerns and appropriate changes had been made. Observations made during our inspection confirmed this.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that annual appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that staff had protected learning time.

The practice was a GP training practice for GP registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine). Two GP partners were responsible for the induction and overseeing of the training for GP registrars. The GP registrar told us there were robust induction procedures in place and they felt well supported.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, a patient's prescription had been sent to the wrong pharmacy. Following an investigation, procedures for recording where new patients would like their prescriptions delivered to were amended and staff were made aware through emails and practice meetings.