The Roxton Practice

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 The Roxton practice on 20 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was good for providing services for the older population, families, children and young people and working age people. The practice was rated outstanding for people with long term conditions.

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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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.

We saw areas of outstanding practice:

- The practice provided an out of hours diabetes service to provide a more effective and responsive service to this group of patients. Patients can access the service, for example on an evening and weekend and by telephone, text and internet support.
- Within the practice there was a Minor Injuries Unit (MIU). This unit was nurse led and offered assessment and treatment of minor injuries and illness to all in the local and surrounding area, including those patients who had been signposted from the NHS 111 service during surgery hours.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Summary of findings

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. Risks to patients were assessed and well managed. There were enough staff to keep patients 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. 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.

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 (CCG) 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

Summary of findings

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 and other stakeholders.

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. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 had commenced an 'Advanced Community Care initiative' which was a unique service giving a personalised responsive service to vulnerable people including complex frail elderly patients. It was established in response to a two year review to reduce pressure on unplanned activity in the local hospital.

A senior GP from the practice has been leading the project to establish a team collaboratively working with other practices and other providers in the locality including community, social work, mental health and the acute trust.

Patients were identified through risk assessment (including computerised fragility index and acute trust activity data) and professional intelligence.

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 and had a range of enhanced services, for example, in dementia and 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.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long term conditions. The practice provided an out of hours diabetes service to provide a more effective and responsive service. A large number of patients within that group were working age adults who would benefit from more intensive support but found clinic times inconvenient and inflexible. In response to the feedback from patients the practice established a service in collaboration with six other practices. Patients from any practice who are unable to attend their own clinics can access the service, for example, evening and weekend clinics and telephone, text and internet support. The practice offers patients a choice of venue and time. Patients using this service have improved their diabetes control and report high satisfaction feedback.

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

Summary of findings

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. The practice developed a children's multi-disciplinary team meeting (MDT) in 2010. The meetings consist of GP's practice nurses health visitors and school nurses to provide holistic and comprehensive care to children. A number of issues are covered at the meetings such as, child protection, complex cases with multiple needs, and developing strategies for immunisations uptake. Since the commencement of the meetings there had been improvements in communication between health professionals for vulnerable children, an increase in immunisation uptake rates and a more collaborative approach to working with children and families.

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. 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.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people. Within the practice there was a Minor Injuries Unit (MIU). This unit was nurse led and offered assessment and treatment of minor injuries and illness to all in the local and surrounding area, including those patients who had been signposted from the NHS 111 service.

As the practice is located close to the docks and petro chemical industry there are a large number of workers and contractors who are away from their registered practice. The practice's own patients are also eight miles away from the local Accident and Emergency department. The practice established the MIU in response to the unmet demand. It is located within the urgent care centre ensuring convenient same day access to a range of professional when required.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the

Summary of findings

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

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for 100% of people with a learning disability and 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 suppported vulnerable patients 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 service offered to people experiencing poor mental health was located over eight miles away from the practice and patients were concerned about the travel and perceived delay between assessment and active treatment. The practice established their own in house service in collaboration with six smaller practices to provide services more local to patients. The feedback has been positive and outcomes have been good.

Nationally reviewed data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. People experiencing poor mental health 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. It also carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We received 18 completed CQC comment cards which patients filled in prior to the inspection. We also spoke with eight patients who were using the service on the day of inspection. The patients we spoke to and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. Patients said they were confident with the care provided, and would recommend the practice to friends and family. They told us they found the staff to be caring, supportive, and provided them with a consistently high level of care. We observed a friendly relaxed environment between staff and patients.

We saw that the practice were continually seeking feedback from patients to shape and develop services in

the future. We saw that patient views were listened to and the results of patient surveys reviewed quarterly.

The GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published in January 2015 showed that 86.8% of patients would recommend their GP (in the middle range). 84.4% scored for opening hours (among the best). 91.42% of patients felt their overall experience was good or very good.

The practice had an established proactive patient participation group (PPG). We spoke with two members of the PPG as part of this inspection. They had been responsible for a range of initiatives and changes, for example changes to the appointment system so that patients were able to see their GP on the same day. They also had input into the on line appointments system and repeat prescriptions on line.

The lead member of the PPG was often in the surgery offering to help patients and to demonstrate new systems, such as the touchscreen booking in system.

We found that the practice valued the views of patients and saw that following feedback from surveys changes were made in the practice.

The Roxton Practice

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 specialist advisor GP, and a Practice Manager.

Background to The Roxton Practice

The Roxton practice provides primary medical services to approximately 17,369 patients in the North East Lincolnshire Commissioning Group (CCG) area. They also have a branch surgery at Keelby which serves the rural areas.

At this practice, there are five partner GP's one associate partner GP and two salaried GP's, a mix of male and female. Patients can be seen by a male or female GP as they choose. There are nurse practitioners, practice nurses and health care assistants based at the practice. They are supported by a team of management, reception and administrative staff. Community Nurses, Midwives, Health Visitors and Community Matrons are among the staff who attend the surgeries on a regular basis. The practice is a training practice and has Foundation Year 2 placements, GP Registrars and medical students from Hull and York Medical School.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; surgical procedures, and treatment of disease, disorder and injury.

The practice has opted out of providing Out of Hours services, which patients access through the 111 service.

The practice is open Monday, Wednesday and Friday. 08:40 – 12.20. 14:00 – 18:00.

Tuesday and Thursday 08:40 – 12:00. 14:00 – 19:30.

Saturday and Sunday. Closed.

Urgent appointments are available daily at the practice and patients are able to telephone the surgery or attend in person for an urgent appointment the same morning and will be offered either a face to face consultation or a telephone consultation with a Doctor or Nurse Practitioner depending on the clinical need.

There is also a Minor Injuries Unit. Accidents and emergencies can be seen here without an appointment (although patients may have to wait and patients are seen in order of clinical need).

The practice is the 'hub of the area' and there is also a coffee shop , run independently where patients or people in the local community can call in and buy snacks and drinks. There is also an area in the practice, set up which has a different health promotion theme every month, for example, healthy eating, stop smoking. Leaflets and information is offered to patients.

Why we carried out this inspection

We carried out the inspection 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

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also spoke with two members of the Patient Participation Group. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 20 January 2015.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GP's, nursing staff, and administrative and reception staff.

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. Prior to inspection the practice gave us a summary of significant events from the previous 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. The practice worked with the Clinical Commissioning Group (CCG) in reporting incidents as necessary.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed the practice was appropriately identifying and reporting significant events.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the previous year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. A significant incident was discussed at a pre-arranged meeting. The practice used agreed action plans to monitor learning and improvement. These actions plans were discussed and reviewed at agreed times. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by email 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. They also told us alerts were discussed at staff meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, 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.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were 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 a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications

about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

The practice was able to identify families, children, and young people living at risk or in disadvantaged circumstances, and looked after children (under care of the Local Authority).

The clinical staff confirmed they were able to identify and follow up children, young people and families. There were systems in place for identifying children and young people with a high number of A&E attendances. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently failed to attend appointments for childhood immunisations were followed up with letters and discussed with the health visitor and could also be included in the monthly MDT meetings.

We saw that staff were aware of and responsive to older people, families, children and young people, vulnerable people and the support they may require. The practice had good awareness of the support organisations in and around the area where patients could receive further support. This included direct links with the local authority and benefits agencies.

The practice had processes in place to identify and regularly review patients' conditions and medication. There were processes to ensure requests for repeat prescribing were monitored by the GPs.

The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as the police, social services and support organisations.

Medicines management

We checked medicines in the treatment rooms and found they were stored securely and were only accessible to authorised staff. We checked medicines in the fridges and found these were stored appropriately. Daily checks took place to make sure refrigerated medicines were kept at the correct temperature. Refrigerated and emergency medicines we checked were in date and there was a process for checking.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice reviewed its prescribing data through clinical audits and communication with the CCG, and had audited, for example, antibiotic use, and prescribing of high risk medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept securely at all times. There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. GPs received repeat prescriptions as authorisation tasks. Where necessary, the patient was seen for a review before the prescription was issued. Patient's medications were reviewed at least annually.

Changes in medication guidance were communicated to clinical staff. They were able to describe an example of a recent alert. Medicine alerts were sent to the prescribing lead who then disseminated the information. This helped to ensure staff were aware of any changes and patients received the best treatment for their condition.

The practice had a prescribing and medication policy which was regularly reviewed and had been agreed with the CCG medicines management team.

Cleanliness and infection control

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

All staff received induction training about infection control specific to their role and received annual updates. The practice had a lead for infection control We saw evidence

that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

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

Equipment

Contracts were in place for checks of equipment such as the fire extinguishers, and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager.

Equipment such as scales, nebulisers and fridges were checked and calibrated yearly by an external company, as well as daily operational checks by staff.

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing and recruitment

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

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 practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and mainly monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment and equipment, and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk.

Patients with a change in their condition or new diagnosis were reviewed appropriately and discussed at clinical meetings, which allowed clinicians to monitor treatment and adjust according to risk. We saw that for all patients with long term conditions there were emergency processes in place to deal with their changing conditions. We saw where learning from incidents had taken place around rapid deterioration in patient's condition and this disseminated through evening education meetings. Therefore the practice was positively managing risk for patients. Information on such patients was made available electronically to out of hours providers so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation.

Good

Are services safe?

We saw records confirming staff had received Cardio Pulmonary Resuscitation training. Staff who used the defibrillator were regularly trained to ensure they remained competent in its use. This helped to ensure they could respond appropriately if patients experienced a cardiac arrest. Staff described the roles of accountability in the practice and what actions they needed to take if an incident or concern arose.

A site specific business continuity plan and emergency procedures were in place which had been recently updated, which included details of scenarios they may be needed in, such as loss of data or utilities. Regular fire alarm checks took place.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. There was also a defibrillator and oxygen available. Processes were in place to check emergency medicines were within their expiry date.

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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 to carry out clinical audits.

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

The practice showed us five clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following advice from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to reduce blood cholesterol levels a clinical audit was carried out. The aim of the audit was to ensure that all patients prescribed this medicine in combination with a particular hypertensive drug were not put at risk of serious drug interactions. The information was shared with GPs and patients were called for a medication review.

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

Good

Are services effective?

(for example, treatment is effective)

long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 87.1% of the total QOF target in 2014. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and hypertension QOF indicators was better than the national average.
- The dementia diagnosis rate was above the national average

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.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence 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 practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, for example, patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions, for example Diabetes, COPD, Heart failure.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as fire and basic life support. We noted a good skill mix among the doctors with number having additional diplomas in family planning, woman's health and substance misuse. All GPs were up to date with their yearly continuing professional development requirements and 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which goals and objectives were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, enhanced services for learning disabilities.

Good

Are services effective?

(for example, treatment is effective)

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, cervical cytology and review of patients with long term conditions. Those nurses with extended roles such and seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also 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 patient's 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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and processed by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and processed on the day of receipt and all within five days of receipt. 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.

The practice held multidisciplinary team meetings every month to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. 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 found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. 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 had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick

Good

Are services effective?

(for example, treatment is effective)

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 policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

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

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

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. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

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 July 2014, a survey undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. (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 evidence showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good was 85%.

In the latest quarterly survey results, which had 71 responses, 82% of patients rated the manner of their doctor as above average or excellent, and 90% for the nurse they saw.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 away from the reception desk which helped keep patient information private. maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

In the NHS England GP survey, 86 % of patients said the GP involved them in care decisions, and 88 % felt the GP was good at explaining treatment and results. Both these results were in line with national averages. Patients we spoke to on the day of our inspection and the comment cards 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. They said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Longer appointments were given where required.

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff provided examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin, or the level of ongoing intervention the patient wished for their condition. Extra time was given during appointments where possible to allow for this.

Patients said the GPs explained treatment and results in a way they could understand, and they felt able to ask

Good

Are services caring?

questions, and felt sufficiently involved in making decisions about their care. GPs told us they used online translation tools or used relatives or friends during consultations for patients whose first language was not English.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support services to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service.

GPs referred patients to bereavement counselling services. When patients had suffered bereavement, GPs were notified, and the practice called next of kin or visited. The practice kept registers of groups who needed extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided.

GP's referred people to counselling services where necessary, and the practice website and handbook contained links to support organisation and other healthcare services. Patients could also search under their local area for further advice and support.

The practice provided information and support to patients who were bereaved and for carers. The practice sign posted patients to health and social care workers and referrals were made on behalf of patient's relatives and carers as appropriate.

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.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice worked closely with the CCG to discuss local needs and priorities. A range of enhanced services were available such as contraception and minor surgery.

The NHS Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

Longer appointments were made available for those with complex needs, for instance patients with hearing difficulties, where a sign language translator was also arranged. Patients could book with a specific GP to enable continuity of care.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow them up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available. Home visits and telephone appointments were available where necessary. Patients could request to book a double appointment needed.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as access without steps, parking, disabled car parking, and toilets for wheelchair users. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

There was a practice information leaflet available. It covered subjects such as services available, GP and patient responsibilities, and how to book appointments.

The practice had recognised the needs of different groups in the planning of its services. For instance GPs worked closely with drug and alcohol services. Patient records were coded to flag to GPs when someone was living in vulnerable circumstances or at risk.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed this training.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

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

Access to the service

Information was available to patients about appointments on the practice website and patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

Patients we spoke to told us they could generally access appointments without difficulty. Opening times and closures were advertised on the practice website, with an explanation of what services were available. Longer appointments were also available for patients who needed them and those with long-term conditions. This also

Good

Are services responsive to people's needs?

(for example, to feedback?)

included appointments with a named GP or nurse. During core times patients could access a mix of doctors, nurses & health care assistants, or clinics such as family planning and for chronic conditions.

Appointments could be made in person, by telephone or online. The practice promoted its online services via the practice leaflet and website. Appointments could be booked up to four weeks in advance, following feedback from the PPG, which helped patients to plan. Urgent appointments could be allocated the same day on clinical grounds, following a telephone assessment. Nurse appointments were also available four weeks in advance.

Appointments were available from 8:40am until 6:00pm Monday, Wednesday and Friday at this practice. Tuesday and Thursday appointments were available from 8.40 to 19.30.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was contained in the patient information leaflet, and staff were able to signpost people to this.

We looked at a summary of complaints made from November 2013 to November 2014. We could see that these had been responded to with an explanation and apology. There was a designated responsible person who handled all complaints which was the practice manager. We were told by staff that they would always try and resolve a complaint that was raised with them at local level and if this was not possible direct them to the practice manager.

We saw that information was available to help patients understand the complaints system in the waiting area, in the practice leaflet or the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice summarised and discussed complaints with staff at practice meetings, and was able to demonstrate changes made in response to feedback, such as allowing appointments to be booked further in advance. Patients we spoke with said they would feel comfortable raising a complaint if the need arose.

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 clear aims and objectives to improve the health and well-being of patients and provide good quality care contained in their statement of purpose. The practice values, vision and goals were discussed with staff at their induction. Examples of the practice objectives included reducing admissions and self-care promotion.

Management staff had a clear business plan for the next year, where they identified the main issues and how they intended to address these for the next year. Staff had specific individual objectives via their appraisal which fed in to these, such as clinical staff looking to develop their knowledge in a certain area to be able to offer additional service.

Governance arrangements

Staff were clear on their roles and responsibilities, and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared computer system, which logged who had read reports. All the policies and procedures we looked at, such as chaperone policy, Mental Capacity Act policy and human resources policies had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. All GP partners had additional areas of responsibility decided across the PMG group, for instance, safeguarding. Monthly management meetings were held and other staff given the opportunity to comment on decisions taken by managing partners. Each partner took responsibility for a specific area of clinical governance which was reviewed at management meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for PMG showed it was performing in line or above national standards. The practice regularly reviewed its results and how to improve. The practice had identified lead roles for areas of clinical interest, safeguarding, or management tasks, and had a coherent strategy and aims for the future. There was a programme of clinical audit, subjects selected from QOF outcomes, from the CCG, following an incident or from the GP's own reflection of practice. Audits on subjects such as prescribing of antibiotics, and use of an anti-inflammatory medicine.

The practice audited many areas monthly, including call waiting times, time taken to process correspondence, and time taken to process referrals. The practice had arrangements for identifying, recording and managing risks. A risk log was kept, which addressed a wide range of potential issues, such as the environment and infection control. We saw that the risks identified were discussed at team meetings and updated in a timely way. The practice held regular practice meetings. We looked at the minutes from the meetings over the last year and found that performance, quality and risks had been discussed.

From our discussions with staff we found that they looked to continuously improve the service being offered, and valued the learning culture. We saw evidence that they used data from various sources including incidents, complaints and audits to identify areas where improvements could be made.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

There was an active Patient Reference Group (PPG), which met on average monthly. Annual patient survey reports and action plans were published on the practice website for the practice population to read. The practice was actively advertising to recruit to the group to ensure it was representative of the practice population.

Are services well-led?

Good

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

The practice had gathered feedback from patients through patient surveys and complaints received. We saw that following the annual surveys priority areas were agreed with the PPG and these formed the basis of the initial practice objectives. Examples of these were improved access to appointments and explain the surgery appointment system clearly for patients. Appointments were now available to be requested on the same day.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. Staff told us they generally felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional or personal development through training and mentoring. We saw that appraisals took place where staff could identify learning objectives and training needs.

The practice was a training practice and supported medical students at the time of inspection. There was also an in-house education programme which staff could access. The practice had completed reviews of significant events and other incidents. Staff told us the culture at the practice was one of continuous learning and improvement.