Danetre Medical 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?	Outstanding

Summary of findings

Contents

Summary of this inspection

Detailed findings from this inspection

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Danetre Medical Practice on 2 December 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents had been maximised.
- Risks to patients had been identified and assessed and well managed to minimise those risks.
- The practice was actively involved with local and national initiatives to enhance the care and treatments offered to patients. Practice staff were proactive in piloting new ways of working to improve meeting the needs of patients.
- Patients we spoke with said they were treated with respect and they felt involved with decisions about their care and treatment. They commented about how helpful staff were towards them. Information was available and details of support groups to help them understand about their care needs.
- Practice staff listened and when possible implemented suggestions for improvements and made changes to the way they delivered services. Information about how to make a complaint was available and easy to understand.
- There was a structured programme in place for staff annual appraisals and for planning their training needs. Staff were actively encouraged to enhance their knowledge and skills.
- There was a clear leadership structure and staff told us they felt supported by senior staff and that there was an open culture throughout. There was a clear vision to promote high standards of care. There was a comprehensive governance system in place to monitor the quality of practice wide performance.

Summary of findings

We saw areas of outstanding practice including:

- A new post of 'care co-ordinator' was established in 2015. The staff member was responsible for the interface and seamless care for patients between primary, secondary (hospital), community care and voluntary organisations. They monitored care of 3% of patients with the most complex needs. The care co-ordinator received and collated information on hospital admissions and discharges including the out of hour's service. They presented information to the lead GP, multidisciplinary teams and all other services involved, such as; social services. They arranged for tests and referrals to be carried out and made courtesy calls to patients who were on the community matron's case list and following discharge from hospital. The system provided a comprehensive audit trail of the care provided; identified where more care was required and liaised with the appropriate care provider. It contributed positively to the Northamptonshire 'frail and elderly' community programme and served to prevent unnecessary hospital admissions.
- Clinicians carried out regional and national clinical research programmes. The GP researcher was supported by a research nurse in carrying out a wide range of programmes. For example, cardiovascular risk management of patients who experienced mental health illness, bowel/lung cancer and antibiotic prescribing for children who were experiencing flu type symptoms. The results of the research were shared widely and influenced appropriate patient care.

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 to all relevant staff to support improvement. Information about safety was recorded, monitored appropriately reviewed and addressed. Risks to patients had been identified, assessed and well managed. There was a recruitment policy and procedure in place to ensure patients safety was protected. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed that all patient outcomes were above the locality and national averages. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used the tool 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 other training needs identified or individual requests were well received by senior staff and procedures were put in place to accommodate them. The practice used innovative and proactive methods to improve outcomes for patients especially those with long term conditions or complex needs. The practice provided health education including displays in the waiting area to raise patient awareness of health conditions and to promote effective use of medicines.

Are services caring?

Good

The practice is rated as good for providing caring services.

We observed a patient-centred culture and feedback from patients about their care and treatment was consistently positive. Patients' views gathered at inspection demonstrated they were treated with compassion, dignity and respect. Patients told us they were involved with decision making about their care and treatment. We saw that staff were courteous and helpful. There was emphasis on ensuring that carers received guidance, support and their health needs were met.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice had good facilities and was well equipped to assess and treat patients needs. Appointments were available from 7.30am each day to improve patient access. Practice staff encouraged patient feedback and where possible implemented suggested improvements. There was an active Patient Relationship Group (PRG) who represented patients and worked with staff in making improvements. The PRG was supported by a Patient Virtual Group (PVG) to further enhance gathering of patients opinions. Information on how to make a complaint was available. We saw that complaints made were investigated and where necessary action taken to prevent similar occurrences.

Are services well-led?

Outstanding 

The practice is rated as outstanding for providing well-led services.

Practice staff promoted high standards and took pride in delivery of a quality and innovative service to its patients. There was an open culture and supportive leadership with a clear vision for quality, improvement and learning. Practice staff held a range of meetings that covered all aspects of patient care and the day to day operations of the practice.

Governance arrangements were underpinned by a clear leadership structure. The practice was well organised and managed to support GP partners in the running of the practice. Staff we spoke with felt there was a strong management structure citing effective management, good team working, an open culture across all staff and opportunities to further develop their roles. All staff we spoke with told us they felt well supported.

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team had introduced several schemes to improve outcomes for patients. For example, introduction of a care co-ordinator.

The latest patient survey identified that patients wanted to be seen by a nurse who specialised in diabetes. Senior staff responded to this by appointing a nurse for the role. Senior staff were aware of the future challenges and these were discussed during management meetings. The practice took an active part in GP education and patient care.

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 good for the care of older people.

Clinical staff were knowledgeable about the health needs of older patients. They kept up to date registers of patients' health conditions and information was held to alert staff if a patient had complex needs. Home visits were made to patients who were unable to access the practice. Practice staff worked with other agencies and health providers to provide support and specialist services when they needed it. Clinical staff had identified those patients who were at risk of unplanned hospital admissions and had developed care plans to support them. Part of the role of the two nurse practitioners involved visiting patients who were not able to access the practice. They carried out assessments and provided care and treatment for patients.

People with long term conditions

Outstanding 

The practice is rated outstanding for the care of people with long term conditions.

Practice staff held information about the prevalence of specific long term conditions within its patient population such as, diabetes and hypertension. Varied appointments were offered to ensure long term conditions were adequately reviewed. Clinical staff kept up to date with specialist areas which helped them ensure best practice guidance was considered. Multidisciplinary and palliative (end of life) meetings were held where patient care was reviewed to ensure they received care that was appropriate for their needs.

A GP and a dedicated research nurse carried out a wide range of clinical research. For example, cardiovascular risk management of patients who experienced mental health illness, bowel/lung cancer and antibiotic prescribing for children who were experiencing flu type symptoms. The results ensured patients received appropriate and treatment to prevent unnecessary deterioration of their conditions.

During 2014-15 93.3% of patients had attended the practice to have their blood pressure checked. To educate and raise patient awareness of the need to attend for this assessment Saturday morning sessions were held by the PRG where patients could drop in to check their blood pressure on the machine that was situated in the waiting area.

Summary of findings

The care co-ordinator role ensured that 3% of patients with the most complex needs obtained seamless, timely and appropriate care. The practice manager told us the system worked in reducing the number of hospital admissions.

The nurse practitioners visited patients in their own homes and those who resided in care homes to review their long term conditions and administer flu vaccinations.

Carers were encouraged to identify themselves, new carers were sent an introductory phone text message followed by a letter and a carers pack.

Families, children and young people

Good

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

Staff were responsive to parents' concerns about their child's health and prioritised appointments for children presenting with an acute illness. The extended morning hours allowed parents to take their children for appointments outside of school hours. Staff were knowledgeable about child protection. Alerts were put onto the electronic record when safeguarding concerns were raised. There was regular liaison with the health visitor to review those children who were considered to be at risk of harm.

Working age people (including those recently retired and students)

Good

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

A full range of health promotion and screening services were provided that reflected the needs of this population group. During 2014 to 2015 there had been an uptake of 100% of available Quality and Outcome Framework (QOF) points for cervical screening. On line appointments, cancelling appointments and repeat prescription requests were available. Appointments were available from 7.30am each day. Telephone consultations were available to those patients who had difficulty in attending or were unsure if they needed to make an appointment. A choose and book referral system was in place to enable patients to choose the provider, date and time that was convenient to them.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of all vulnerable patients including those who had a learning disability. Longer appointments were routinely available for this group of patients and the practice contributed

Summary of findings

towards their health action plans. There was a clinical lead for dealing with vulnerable adults and children. Staff had been trained in recognising signs of abuse and how to respond to concerns. We saw evidence that staff had responded appropriately to safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

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

Clinical staff worked with specialist services to review care and to ensure patients received the support they needed. Staff maintained a register of patients who experience poor mental health including dementia. Patients were referred to appropriate services such as psychiatry and counselling services. Clinical staff had received training and were aware of their responsibilities under the Mental Capacity Act 2005 and in respect of gaining consent for patients care and treatment.

Regular reviews were offered towards the end of the day because the practice experienced a high did not attend (DNA) rate when earlier appointments were provided.

Patients who experienced poor mental health and depression were referred to an in-house a counsellor who visited the practice each week to provide non-medical advice and support to assist patients in coping with their lifestyles and condition.

The local county council held three well-being sessions per week at the practice. Their aim was to provide access to services for people who were experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above local and national averages. There were 113 responses, this equated to 43% of the number of surveys issued.

- 97% found the receptionists at this surgery helpful compared with a CCG average of 86% and a national average of 87%.
- 76% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 67% and a national average of 65%.
- 76% felt they did not normally have to wait too long to be seen compared with a CCG average of 58% and a national average of 58%.
- 92% said last time they spoke with a GP they were good at giving them enough time compared with a CCG average of 85% and a national average of 87%.
- 81% found it easy to get through to this surgery by phone compared with a CCG average of 71% and a national average of 73%.
- 96% said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.

During our inspection we spoke with 11patients. All patients told us they were satisfied with the service they received. As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 33 comment cards and all were positive about the standard of care they received. Some described their care as excellent and truly exceptional. We spoke with seven members of the Patient Relationship Group (PRG) who were also registered patients. PPG's work with practice staff in an effective way that may lead to improved services. Some described the care they had received and how they were impressed with the service.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that the reception desk is staffed at all times when the practice is open.

Outstanding practice

- A new post of 'care co-ordinator' was established in 2015. The staff member was responsible for the interface and seamless care for patients between primary, secondary (hospital), community care and voluntary organisations. They monitored care of 3% of patients with the most complex needs. The care co-ordinator received and collated information on hospital admissions and discharges including the out of hour's service. They presented information to the lead GP, multidisciplinary teams and all other services involved, such as; social services. They arranged for tests and referrals to be carried out and made courtesy calls to patients who were on the community matron's case list and following discharge from hospital. The system provided a comprehensive audit trail of the care provided; identified where more care was required and liaised with the appropriate care provider. It contributed positively to the Northamptonshire 'frail and elderly' community programme and served to prevent unnecessary hospital admissions.
- Clinicians carried out regional and national clinical research programmes. The GP researcher was supported by a research nurse in carrying out a wide range of programmes. For example, cardiovascular risk management of patients who experienced mental health illness, bowel/lung cancer and

Summary of findings

antibiotic prescribing for children who were experiencing flu type symptoms. To date between 25 and 30% of patients registered at the practice had willingly participated with the research. The findings were presented widely to influence the care and treatment patients received. The results of the research were shared widely and influenced appropriate patient care.

Danetre Medical 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 GP and a practice manager, specialist advisors.

Background to Danetre Medical Practice

Danetre Medical Practice is located on the local community hospital site and serves approximately 12,600 patients from Daventry town. The practice holds a Primary Medical Services contract and provides GP services commissioned by NHS England. The practice is preparing to move to a General Medical Services contract.

The practice is managed by four GP partners (one male, three female) and there are four salaried GPs who between them provide 57 clinical sessions per week. They are supported by two nurse practitioners, five practice nurses and three healthcare assistants. Nurses have dedicated roles such as diabetes management and immunisations. One GP carries out research and is supported by a research nurse who works two sessions per week. The practice employs a practice manager, a corporate services assistant, an operations manager, a patient services team leader, a care coordinator, a support services team leader and a prescribing technician who received requests and organised repeat prescriptions. They are supported by 18 administration and reception staff who includes team leaders.

The practice is a teaching and training practice, which supports and mentors trainee GPs.

The practice is open from 7.30am until 6.30pm each day. Each GP has varied timings for their clinical sessions so appointment timings will differ depending on which GP a patient is seen by. Appointments commence at 7.30am until 10.30am, 11am until 12.30pm and 1.30pm until 6.30pm each weekday. However, the duty GP will see patients at any times during the opening hours. There are a range of appointment types including' on the day' and advance appointments up to four weeks. Urgent appointments are available on the day. Telephone consultations are available for patients who are unsure if they need an appointment and for provision of advice for children.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided currently by a service commissioned by NHS Nene Clinical Commissioning Group (CCG).When the practice is closed, there is a recorded message giving out of hours' details.

Why we carried out this inspection

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

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

Detailed findings

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 December 2015. During our visit we spoke with a range of staff including four GPs, an advanced nurse practitioner, two practice nurses, one HCA, the practice manager, care coordinator, receptionists and a secretary. We spoke with 11 patients and seven members of the Patient Participation Group (PPG). PPG's work with practice staff in an effective way that may lead to improved services. We observed how people were being cared for and talked with family members and reviewed the personal care or treatment records of patients. We reviewed 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

Safety was a priority and staff used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

Practice staff carried out an analysis of all significant events. We viewed the significant events for the previous 12 months and found evidence that all events had been recorded, investigated, discussed with relevant staff and any learning from them clearly documented and shared. For example, the reason in a delay for a referral was investigated and systems put in place to prevent a similar recurrence.

Safety was discussed during the daily GP informal meetings and formal clinical and business meetings. Where common themes were identified changes were made in order to address them. Weekly safety meetings included topics such as; health and safety, risk assessments, safe prescribing and identifying where improvements could be made to promote patient and staff safety.

Patient safety alerts were disseminated to staff and where necessary actions were taken to promote patient safety and we saw evidence of this.

Overview of safety systems and processes

Arrangements were in place to safeguard children and adults from abuse that reflected relevant legislation. Local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were lead members of staff for safeguarding. Staff had received safeguarding training relevant to their role. Staff we spoke with were able to demonstrate good knowledge and understood their responsibilities in respect of safeguarding.

The practice kept a register of vulnerable children and adults and it was regularly checked to ensure it remained up to date. Senior staff held weekly meetings and monthly multidisciplinary meetings to discuss patients who were considered to be at risk. Safeguarding was a standing agenda item for all practice meetings.

Notices were displayed around the practice advising patients that they could request a chaperone. All staff who acted as a chaperone were trained for the role and had received a disclosure and barring (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Some patients we spoke with were aware that they could request a chaperone. Staff we spoke with demonstrated that they had good knowledge about the role of chaperoning.

There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, clinical waste and legionella. Legionella is a term used for particular bacteria which can contaminate water systems in buildings.

There were suitable infection control policies and procedures in place which covered a wide range of areas including hand hygiene, vaccine storage and handling specimens. Training records we viewed showed that all staff had received training in infection control. The recently appointed lead for infection control acknowledged that they needed to complete more in depth training to fully equip them for the role.

We saw that all areas of the practice were visibly clean and tidy and there was an ample supply of liquid soap and paper towels in toilets. We saw a comprehensive audit report dated December 2014. It included where actions for improvements were required. We were shown a copy of the action plan and saw that all areas for improvements had been addressed. We were told that the next audit was due to be carried out.

Recruitment checks were carried out and we were shown these for a range of staff. They showed 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. There was staff induction programmes and these were tailored to the staff roles.

Good

Are services safe?

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Non-clinical staff absences were covered by other staff working extra shifts. The practice had two bank nurses who could provide cover during holidays and sickness. Locum GPs were used to cover GP absences.

Staff told us the practice was well equipped and requests for repairs or replacement were dealt with promptly. We saw records that confirmed equipment was tested and regularly maintained. Medical equipment had been calibrated in accordance with the supplier's instructions.

Practice staff had access to comprehensive policies and procedures in respect of a safe management of medicines and prescribing practices. The practice had written procedures in place for the production of prescriptions that had recently been reviewed and accurately reflected current practice. There was a process in place to ensure patients were advised of review dates and reauthorisation of repeat medications was only actioned by clinicians. We saw evidence that patients who were prescribed medicines considered a high risk were offered regular reviews and checks to ensure their medicines dosage were appropriate.

We checked that medicines were securely stored at the practice and only accessible by authorised staff. Checks were made on the expiry dates of all medicines and those we checked were within their expiry dates. The fridge temperatures were recorded where vaccines were stored and expiry dates had been checked.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen. There was a formal medical emergency protocol in place and when we discussed medical emergencies with staff, they were aware of what to do.

There was a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this was held off site to ensure that appropriate response would be instigated in the event of eventualities such as loss of computer and essential utilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with were able to clearly define why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to access National Institute for Health and Care Excellence (NICE) guidelines. From discussions held with clinical staff we were able to confirm they completed thorough assessments of patients' needs and these were reviewed when appropriate.

Chronic disease management clinics were held to cover a wide variety of diseases and when necessary appointments were extended to ensure all aspects of needs and treatments were assessed and reviewed. Care plans were developed for all patients who were vulnerable or had had complex needs and these were regularly reviewed.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had achieved 100% for all QOF data for 2014-2015;

- The dementia review rate of 100% was 2.8% above the CCG and 5.5% above the national average. The practice exception rate was 4.6%.
- The mental health review rate of 100% was 4.2% above the CCG average and 7.2% above the national average. The practice exception rate was 4.3%.
- Performance for asthma related indicators was 100% which was 1.4% above the CCG average and 2.6% above the national average. The practice exception rate was 8.3%.
- Performance for patients with a learning disability was 100% which was the same as the CCG average and 0.2% above the national average. The practice exception rate was zero.
- Performance for diabetes related indicators was 100% which was 7.6% above the CCG average and 10.8% above the national average. The practice exception rate was 5.5%.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were 100% which was 2.2% above the CCG average and 4.0% above the national average. The practice exception rate was 6.8%.

The practice had exception reporting of 9.6%, which was 1.1% less than the local Clinical Commissioning Group (CCG) average and 0.4% above the national average. Exception reporting is the exclusion of patients from the list who meet specific criteria. For example, patients who choose not to engage in screening processes. The practice manager informed us that some patients had declined to take their prescribed medicines such as; statins (cholesterol reducing medicines) due to adverse press releases. Clinical staff had recorded those patients who had refused to attend for their annual review of their long term health condition.

With the exception of blood pressure checks (93.3%) the practice had achieved 100% of available points for public health data for 2014-2015. For example, contraception and cervical screening. In response to those patients who had not attended the practice for their blood pressure check the Patient Relationship Group (PRG) organised two Saturday morning sessions to raise awareness. Patients were encouraged to attend to use the self-assessment area to measure their height and weight, to check their blood pressure and talk with members of the PRG. The PRG were proactive in representing patients and assisting the practice in making improvements. The practice manager told us the sessions were well attended. Plans were in plan to repeat the event. There were posters on display that advised patients about the normal blood pressure range. We were told that the sessions were well attended.

There were numerous examples of clinical audits completed by the GPs. The audits identified where improvements to patients care were to be made. The changes in treatments led to improved patient care. The audits indicated that it would be repeated to ensure that the changes made had been sustained.

Good

Are services effective?

(for example, treatment is effective)

A GP attended the regular CCG prescribing group meetings to discuss and where possible make improvements to patient care through the prescribing process. For example, a switch from one medication to another for a certain disorder had resulted in identified patient improvement. A prescribing audit had been carried by Northamptonshire prescribing Advisory Group and recordings of recommendations dated August 2015 had been sent to the practice for dissemination to all clinical staff for implementation and improvement in patient outcomes.

Clinicians carried out regional and national clinical research programmes. The GP researcher was supported by a research nurse in carrying out a wide range of programmes. For example, asthma, kidney disease, management of gout (painful toe condition) and atrial fibrillation (irregular heart beat). At the time of the inspection research was being conducted on 'statins' (medicines used to treat high or unsafe cholesterol levels. To date between 25 and 30% of patients registered at the practice had willingly participated with the research. The findings were presented to other clinicians at the practice and widely to others to influence the care and treatment patients. received. Quarterly newsletters were circulated to staff to keep them informed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- There was an induction programme for all newly appointed staff that was relevant to their role. It covered topics such as; safeguarding, fire safety, health and safety and confidentiality. Clinical staff and locum GPs were also supported according to their need and ability. All staff were informed how to access practice policies and issued with a contract which contained detailed information.
- All staff we spoke with told us they felt supported to access further education and training. Learning needs of staff were identified through the appraisals system, meetings and reviews of practice development. Staff had access to appropriate training to meet their training needs and to cover their scope of work. Staff told us there was mutual respect throughout and were offered guidance when required. All staff had received an appraisal within the last 12 months.
- Registered nurses had received further education and support to keep their knowledge and skills up to date.
- There was monthly half day protected learning time for staff. These consisted of in-house training and learning through discussions, locality meetings and CCG wide training courses.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient records and their intranet system. This included care and risk assessments, care plans, medical records and test results.

Staff worked together with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients were referred and after discharge from hospital. Daily informal clinical and weekly formal meetings were held. Monthly multidisciplinary meetings were held and practice staff had easy access to other on-site professionals at short notice. GPs held quarterly meetings where they discussed deaths and cancer patients to ensure they had delivered appropriate care and where changes could be made.

At the beginning of 2015 senior staff created a new post 'care co-ordinator' with the intention of having positive impact on the care of patients. The recruited staff member was responsible for the interface and seamless care for patients between primary, secondary (hospital), community care and voluntary organisations. The care co-ordinator received and collated information on hospital admissions and discharges including the out of hour's service. They presented the information to the lead GP, multidisciplinary teams and all other services the patient had been involved with, such as; social services. They developed a record-keeping and communication system and ensured that all information and actions about patients was updated. They arranged for tests and referrals to be completed. The care co-ordinator carried out courtesy calls to patients who were on the community matron's case list. They also contacted patients when they were discharged from hospital to enquire if all of their needs had been met and inform relevant staff where gaps were reported. The case load comprised of 3% of the most complex cases with care plans in place. The system provided a clear and comprehensive audit trail of the care

Good

Are services effective?

(for example, treatment is effective)

provided; identified where more care was required and liaised with the appropriate care provider. It contributed positively to the Northamptonshire 'frail and elderly' community programme and served to prevent unnecessary hospital admissions. The practice manager told us that this scheme had had a positive impact on the reduction of hospital admissions.

The nurse practitioners visited patients in their own homes and those residing in care homes. They carried out reviews of long term conditions and administered flu vaccinations. They work together with the Collaborative Care Team (CCT) who also visited patients at home and in care homes. The practice joint funded the CCT with the Clinical Commissioning Group (CCG). Both liaised with the care co-ordinator and district nurses to ensure that patients with the most complex needs received integrated care.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When consent was obtained it was recorded in the patient's medical records in line with legislation and relevant national guidance.

Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

All clinical staff knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. Staff understood the key parts of legislation of the Children's and Families Act 2014. GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment). Two patients we spoke with described how a GP spoke with and treated their child in an appropriate way.

Patients we spoke with told us they were consulted and their care needs were explained to them so that they understood and agreed with their treatment needs. Consent had been sought before patients had procedures and minor surgery.

Health promotion and prevention

There was a range of information and contact details of support groups on display within the waiting area. For example, health promotion, mental health, stress and a range of long term conditions. The practice website also provided information and advice about minor illnesses.

Childhood immunisation rates for vaccinations given were comparable to CCG and national averages for 2014-15. For example, childhood immunisation rates for the vaccinations given to under two year olds were 97% and five year olds 94% was achieved.

Cervical screening uptake for 2014-15 was 80.8% compared with the national average of 81.3%. Available points for contraception advice was 100% compared with 99% CCG average and 96.1% national average.

All patients who had attended the practice had been counselled by practice staff regarding smoking or how to reduce their weight and lead a healthier lifestyle.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74 years. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities were identified or suspected.

Patients who experienced depression were referred to an NHS counsellor who visited the practice every week to see patients. They offered patients advice and support mechanisms for dealing with their depressions.

Regular newsletters were developed and given to patients. These included developments and clinical services within the practice such as; encouraging patients to have their flu vaccination.

Practice staff displayed health promotion in the waiting area, topic changed every four months. During our inspection the display informed patients that they should not take medicines unless they needed to.

Staff produced a quarterly newsletter that was distributed to patients. It provided information about changes and improvements within the practice as well as health advice and information about the flu clinics that patients could attend.

The practice funded and provided the services of a cognitive behavioural therapist for patients who

Good

Are services effective?

(for example, treatment is effective)

experienced poor mental health and depression. They provided two sessions per week and gave non-medical advice and support to assist patients in coping with their lifestyles and condition.

The practice provided premises and administration assistance to the local county council who held three well-being sessions per week at the practice. Their aim was to provide access to services for people who were experiencing poor mental health.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that all staff were courteous and very helpful to patients both in person or on the telephone and that people were treated with dignity and respect. Curtains were used in consulting rooms to protect patient's privacy and dignity during examinations. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard outside of them. Reception staff told us that they would invite patients to move to an unoccupied room of the practice when patients needed to discuss sensitive issues or personal issues.

Positive comments were made by all 33 patients in the comment cards and stated how pleased they were with the care they received. Others stated that care was excellent, exceptional, efficient and how helpful staff were. The 11 patients we spoke with told us they were happy with the services they received. We spoke with seven members of the Patient Relationship Group (PRG) on the day of our inspection. They told us they were satisfied with the care provided by practice staff and said their dignity and privacy were always respected.

Results from the National GP patient survey dated July 2015 showed how patients were treated. The practice was generally in line with the CCG and national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 89% said the last GP they saw or spoke with was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 90% said the last nurse they spoke with or saw was good at treating them with care and concern compared to the CCG average of 90% and national average of 91%.
- 99% of patients said they had confidence and trust in the last nurse they saw or spoke with compared to the CCG average of 97% and national average of 97%.

Care planning and involvement in decisions about care and treatment

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 available to them. Patient feedback on the comment cards we received was positive and aligned with these views.

Data from the National GP Patient Survey July 2015 information gave opinions about how patients were involved with planning and making decisions about their care and treatment. For example:

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 86% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 76% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 82%.

Staff told us that translation services were available for patients who did not have English as a first language. Staff employed at the practice spoke a range of languages to assist with patients understanding of their health needs.

Patient/carer support to cope emotionally with care and treatment

A nurse prescriber was the designated 'carers champion'. They developed the carer's policy, a toolkit of other documents, a dedicated notice board and checked that carers were identified and offered support. They checked that carers were offered extra health options such as; flu vaccinations. Carers were encouraged to identify themselves, new carers were sent an introductory phone text message followed by a letter and a carers pack. The nurse prescriber put systems in place to enable referrals to Northamptonshire Carers Association. The practice website

Good

Are services caring?

included a dedicated carers section to enable them to obtain information when the practice was closed. Clinical staff offered guidance to carers in how they could support the patients they were looking after.

Following a bereavement a GP offered the family an appointment and if necessary referral to a counselling service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Clinical staff worked with the local CCG to improve outcomes for patients. For example, the practice offered a range of enhanced services such as; 24 hour blood pressure monitoring, changes of urinary catheters and spirometry (breathing test).

The monthly multidisciplinary meetings discussed the care needs of palliative (end of life) care needs who were at risk of unplanned hospital admission.

The active Patient Relationship Group (PRG). PRG's are a group of patients registered with a practice who work with the practice to improve services and the quality of care. They met every two months and played an active role in supporting the practice and making improvements. For example, members of the PRG had assisted with the Saturday morning flu vaccination clinics by sign posting patients. They had taken over the responsibility for maintaining the notice boards within the waiting area to ensure that information was pertinent and helpful. A previous patient survey had said that patients would prefer a practice nurse lead for those who had diabetes and senior staff had responded to this request.

Part of the role of the two nurse practitioners involved visiting patients who were not able to access the practice. They carried out assessments and provided care and treatment for these patients.

Patients who experienced depression were referred to a counsellor who visited the practice each week to provide non-medical advice and support to assist patients in coping with their lifestyles and condition. Reception staff had received training in dementia awareness to assist them in identifying patients who may need extra support.

Clinical staff held weekly meetings for identifying patients who had not attended for their reviews. Those patients were contacted and encouraged to attend an appointment. In some cases a nurse practitioner visited the patient at home to carry out their review and check on their well-being. Patients with long term conditions were risk assessed to identify those in need of enhanced care.

Access to the service

The practice was open from 7.30am until 6.30pm each day. Each GP held varied timings for their clinical sessions so appointment timings would differ depending on which GP a patient was seen by. Appointments commenced at 7.30am until 10.30am, 11am until 12.30pm and 1.30pm until 6.30pm each weekday. However, the duty GP would see patients at any times during the opening hours. There were a range of appointment types including' on the day' and advance appointments up to four weeks. Urgent appointments were available on the day. Telephone consultations were available for patients who were unsure if they need an appointment and for provision of advice for children.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment were above the local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 81% of patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 73%.
- 87% of patients described their experience of making an appointment as positive compared to the CCG average of 73% and national average of 73%.
- 82% reported they were satisfied with the opening hours compared to the CCG average of 75% and national average of 75%.

We spoke with a receptionist who told us that one staff member was assigned to the reception desk. Their role was to receive patients who arrived for appointments and to issue requested repeat prescriptions. We asked about the occasions when they needed to leave the desk and they told us it was not covered. The PRG also commented to us about occasions when the desk was not staffed and that it posed a health and safety risk. We raised this with the practice manager who told us that staff should ring the administration office to request another staff member to cover the desk. They told us there was a policy and lone worker risk assessment in place and that a request should be made by phone to other staff to request relief. Information provided to us suggested that staff were not following the practice procedure.

There were two check-in screens for patients to access to reduce the time they waited to confirm their attendance for appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated staff member responsible who handled complaints. Information about how to make a complaint was available in the waiting area in the format of a leaflet/form that patients could take away with them to complete.

The complaints policy clearly outlined a time framework for when the complaint should be acknowledged and responded to. The policy included details of who to contact if the complainant was not happy with the outcome of their complaint.

The practice kept a complaints log for written complaints. There had been 19 during the last 12 months. We saw that they had been investigated and responded to in line with the practice policy.

Are services well-led?

Outstanding ☆

(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. The mission statement was available in the waiting area for patients to access. Staff we spoke with knew and understood the values of the practice. During our inspection staff displayed enthusiasm in setting and achieving targets and objectives.

There was a strategic plan in place that was dated from 2013 to 2020. It included seven goals that embedded continuous progress towards holistic care for patients. For example, an organisation that promotes a culture of inspiration, maturity and accountability and to be health care professionals who were dedicated to providing patient care.

Staff were attempting to maintain the same current services provided to patients. With the impending change of contract from PMS to GMS senior staff had submitted applications for funding to continue with enhanced services they were already providing. For example, dressing of leg ulcers, phlebotomy, changing of urinary catheters and 24 hour blood pressure monitoring.

Governance arrangements

The practice had achieved high results in QOF data for 2014-2015 and where there was a shortfall action had been taken to make improvements. (This is a system intended to improve the quality of general practice and reward good practice). There were weekly clinical meetings where safeguarding and complex cases were discussed. NICE guidelines and new services were also discussed. A GP and the practice manager were responsible for overseeing QOF data. Weekly reminders were sent out to staff to ensure their continued awareness and reminders were set up in the online system as well as the default reminders. Senior staff had implemented dedicated clinics for annual reviews of patients with chronic obstructive pulmonary disease to promote timely reviews.

The monthly half day of protected learning times were structured to maximise the opportunity this provided. All staff were encouraged and supported to undertake further training and their suggestions for change were considered. For example, the proposal to change the way that healthcare assistants worked to ensure that one was on duty at all times that the practice was open. Their training needs had been reviewed to maximise their potential skills. This suggestion had been made by a practice nurse and acted on.

The practice had an overarching governance framework which supported delivery of its vision and strategy and good quality care. This outlined the structures and procedures in place:

- There was a clear staffing structure and that staff were aware of their roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- There was a comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements was in place.
- There were robust arrangements for identifying, recording and managing risks, issues and for implementing mitigating factors.

Leadership, openness and transparency

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager and staff. There were clearly identified roles within the practice for both clinical and administrative areas. For example, safeguarding, prescribing, infection control and research.

There were strong links with the local CCG with a GP and the practice manager attended the meetings. Information and initiatives were cascaded to other relevant staff. A GP chaired the Local Medical Committee meetings whose aim was to share best practice and make improvements.

The partners and the practice manager have the knowledge and experience to run the practice and to ensure delivery of high quality care. They prioritised safe, high quality and compassionate care. The partners and practice manager were visible and staff told us they were approachable and always took time to listen to all members of staff. Partners and non-clinical senior staff encouraged openness and honesty.

Are services well-led?

Outstanding ☆

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

Staff we spoke with told us about the regular team meetings and that they were encouraged to raise issues and make suggestions. They told us that senior staff considered suggestions and whether they could be introduced.

Staff received a weekly bulletin about changes and improvements in the practice. Staff told us they appreciated and learnt from the bulletins. They said these stimulated discussions between staff about how changes could be effectively implemented.

Communications across the practice was structured around key scheduled meetings:

- Daily informal clinical meetings by GPs.
- Weekly safety meetings.
- Monthly multidisciplinary meetings.
- Quarterly cancer and deaths meetings.
- Monthly patient and support services meetings
- Management board meetings every two weeks.
- Partnership board meetings were held weekly.
- Monthly meetings for non-clinical staff.
- The practice was a member of a federation group to improve services and these meetings were attended.
- Monthly CCG locality board meetings. One GP was the chair person for these meetings.
- Quarterly CCG prescribing group meetings.
- The practice was a member of the local federation group whose aim was to improve services. A practice GP attended the monthly meetings and the practice manager was the designated chair of the federation group.

The practice was well organised and managed to support GP partners in the running of the practice. Staff we spoke with felt there was a strong management structure citing effective management, good team working, an open culture across all staff and opportunities to further develop their roles. One nurse particularly valued what they described as a 'flat' hierarchical structure within the practice.

Staff employed other methods of educating patients. For example, the display and information in the waiting area about inappropriate use of medicines. The topic was changed every four months. A further method was the seasonal newsletters that were distributed to patients.

The latest patient survey identified that patients wanted to be seen by a nurse who specialised in diabetes. Senior staff responded to this by appointing a nurse for the role.

Practice seeks and acts on feedback from its patients, the public and staff

There were strong relationships with the PRG and the chair person attended the locality meetings. The PRG was backed up by the 450 members of the Patient Virtual Group (PVG) in identifying where improvements could be made. The PVG were contacted electronically to gain their opinions about the service. Senior staff listened to what patients told them and as a result established a practice nurse who led on diabetes.

Staff had responded to the statistics regarding patients who should have attended regularly to have their blood pressure checked. In conjunction with the PRG staff had organised a number of Saturday open morning sessions for patients to drop in to the practice to educate and raise their awareness of the need to attend regularly to have their blood pressure checked.

Senior staff had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team had introduced several schemes to improve outcomes for patients. For example, the care co-ordinator who ensured that patients with the most complex needs received integral care.

Senior staff had identified and introduced a care coordinator who was responsible for the interface and seamless care for patients between primary, secondary (hospital), community care and voluntary organisations. The care co-ordinator received and collated information on hospital admissions and discharges including the out of hour's service.

A 'carer champion' had been appointed who liaised with carers and patients and provided them with information

Are services well-led?

Outstanding ☆

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

and access to support services. Carers were offered extra health options such as; flu vaccinations. The practice website included a dedicated carers section to enable them to obtain information when the practice was closed.

The practice was aware of future challenges and had plans in place to further promote patient well-being. For example, the likely increase in the Daventry population that would impose a larger list of registered patients. Senior staff were proactively holding discussions about how more patients could be accommodated.

Clinicians carried out regional and national clinical research programmes. The GP researcher was supported by a research nurse in carrying out a wide range of programmes. The findings were presented widely to influence the care and treatment patients received.

There was a strong focus on continuous learning and improvement at all levels. The practice team was forward thinking; the research and participating in local pilot schemes contributed to improvements for patient care.