Bridgegate Medical Centre

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bridgegate Medical Centre on 7 May 2015. The practice was rated as good for all domains and for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- 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.
- The practice had achieved a score of 100% of the percentage points available to them for Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. QOF is a voluntary incentive scheme for GP practices in the UK for providing recommended treatments for the most commonly found clinical conditions.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Data showed that patients rated the practice higher than others for several aspects of care. We saw that staff were considerate with patients, treated them with understanding and maintained confidentiality.
- Information about services and how to complain was available and easy to understand.
- Patients we spoke with indicated they felt they could obtain appointments, including urgent appointments, when needed. The practice were aware of the needs of the local population and there was good continuity of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.

We saw areas of outstanding practice including:

- The practice had set up a maternity services liaison group with one of the GP partners the lead for this. The aim being to work with young mothers, in particular teenage mothers, to discuss and offer support to them whilst pregnant and after they gave birth to their child.
- The practice was a member of the local education and skills partnership and were engaging with a local primary school to make a health promotion video, therefore increasing the awareness of good health to children.

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

The provider should:

- Improve systems in place to maintain the security of blank computer prescription forms.
- Improve the systems in place to monitor when the privacy curtains in consulting rooms are cleaned.
- Carry out a health and safety risk assessment and regular fire evacuation drills.
- Formally appraise the practice manager.
- Carry out two cycle clinical audits.

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. Patients and staff were protected by safety systems. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used opportunities to learn from incidents to support improvement. The practice had regular multidisciplinary meetings to discuss the safeguarding of vulnerable patients. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed. The practice had enough staff in place to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. We saw the practice had achieved a score of 100% of the percentage points available to them for providing recommended treatments for the most commonly found clinical conditions. This was above both the local clinical commissioning group (CCG) by 5.1 percentage points and England averages by 6.5 percentage points.

Staff referred to guidance from the National Institute for Health and Care excellence and used it routinely. Patients' needs were assessed and care and treatment was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The practice had systems in place for completing clinical audit cycles to review and improve patient care. Staff had received training appropriate to their roles and any further training had just been identified and planned for. There was evidence of appraisals for all staff except the practice manager. Staff worked with multidisciplinary teams. Discrimination was avoided when making care and treatment decisions.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice above the national averages for being caring. Patients told us that patients were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Information to help patients understand services available was easy to understand. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

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Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population to secure improvements to services where these were identified. Patients said they found it easy to make an appointment, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and business plan and they knew what the priorities for the practice were. 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. 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. All patients over the age of 75 had a named GP and were invited to the practice for an over 75 health check. For over 15 years the housebound patients and patients in nursing or residential care received their flu vaccines in September or October, the practice nurse used this opportunity to carry out reviews of long-term conditions and take blood tests at the same time. High risk groups of elderly patients, such as those receiving palliative and residential care had care plans in place. Two of the GPs had completed diplomas in palliative care and another a diploma in geriatric medicine. Patients experiencing dementia received annual reviews and the practice had a dementia diagnosis rate of 85%, the CCG average was 54%. The practice had a palliative care register and had weekly practice and quarterly multidisciplinary meetings to discuss patients and their families' care and support needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Recall appointments were aligned to the patients birthday month and a holistic review of the patients long-term conditions would be carried out in one appointment where possible. Patients with diabetes received six monthly checks. The health care assistant managed the recall register. High risk patients with long term conditions were included in care planning and had a named GP. The practice received maximum points (100%) for QOF in the management of all long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy, which was above all of the clinical commissioning group (CCG) and England average percentage points.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice offered child health clinics for children under the age of five in conjunction with the health visitor, practice nurse and a GP; immunisations were available for all children. There were also antenatal clinics. Last year's performance for immunisations was below or in line the averages for the clinical commissioning group (CCG). For example, infant meningococcal C (Men C) vaccination rates for two year old children were 94.8%

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compared to 97.9% across the CCG; and for five year old children were 96.6% compared to 96.6% across the CCG. The practice had "pink card" appointments which were specifically held back at times suitable for children after school.

The practice had set up a maternity services liaison group with one of the GP partners the lead for this. The aim being to work with young mothers, in particular teenage mothers, to discuss and offer support to them whilst pregnant and after they gave birth to their child. An issue identified from this group was that young mothers felt isolated whilst in hospital. They were unaware that Wi-Fi was in the local hospital which the hospital was then able to promote to young mothers.

The practice was a member of the local education and skills partnership and were engaging with a local primary school to make a health promotion video, therefore increasing the awareness of good health to children.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students. The needs of the working age population (including those recently retired and students) had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended opening hours 7:00am until 7:00pm mid-week. There was on-line access available to book appointments and order repeat prescriptions. There was information on the practice website regarding family health, long term conditions and minor illness and health clinics. The practice offered a range of health clinics which included; travel vaccines, flu vaccines, family planning, cervical screening and NHS health checks for those aged between 40 and 75.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and organisations. Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. The practice maintained a register for patients with a learning disability and they received an annual health check. Drug and alcohol workers offered an open access service to patients at the surgery. There was

Summary of findings

a dedicated board with information on the local carer's association and dates a support worker would be in the practice to hold clinics to support carers. The practice had access to translation services, including sign language, if required.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice worked closely with mental health services. Referrals were made to counselling and organisations such as MIND. Patients experiencing poor mental health received annual health reviews. Patients experiencing dementia received annual reviews and the practice had a dementia diagnosis rate of 85%, the CCG average was 54%.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of our inspection; this included two members of the patient participation group (PPG). All of the patients were satisfied with the care they received from the practice and said their dignity and privacy was respected. They found staff helpful and friendly. Patients commented that they thought they received a good service from the practice, they found it easy to obtain an appointment and all said they would recommend the practice to friends and family.

We reviewed two CQC comment cards completed by patients prior to the inspection. One was positive and praised the practice. The other card was negative regarding an appointment with the practice nurse, which we raised with the practice staff.

The latest GP Patient Survey published in January 2015 showed the majority of patients were satisfied with the services the practice offered. The majority of patients who responded described their overall experience as good. (91% compared to the local clinical commissioning group (CCG) average of 89%)

The three responses to questions where the practice performed the best when compared to other local practices were:

- 78% of respondents usually wait 15 minutes or less after their appointment time to be seen (local CCG average: 66**%**)
- 98% of respondents find the receptionists at this surgery helpful (local CCG average: 90%)
- 89% of respondents find it easy to get through to this surgery by phone (local CCG average: 81%)

The three responses to questions where the practice performed least well when compared to other local practices were:

- 84% of respondents say the last appointment they got was convenient (local CCG average: 94%)
- 76% of respondents would recommend this surgery to someone new to the area (local CCG average: 81%)
- 75% of respondents are satisfied with the surgery's opening hours (local CCG average: 80%)

These results were based on 134 surveys that were returned from a total of 329 sent out; a response rate of 41%.

In the practice's own survey of 2014 patient feedback included;

- Patients said they were completely or very satisfied with the overall service from the practice – 77.5% (22.5% were fairly satisfied with no negative responses).
- How well did the doctor put the patient at ease during the consultation – 97.8% rated this as excellent or good.
- The doctor listened to patients – 92.9% rated this as excellent or good.

Areas for improvement

Action the service SHOULD take to improve

- Improve systems in place to maintain the security of blank computer prescription forms.
- Improve the systems in place to monitor when the privacy curtains in consulting rooms are cleaned.
- Carry out a health and safety risk assessment and regular fire evacuation drills.
- Formally appraise the practice manager.
- Carry out two cycle clinical audits.

Summary of findings

Outstanding practice

- The practice had set up a maternity services liaison group with one of the GP partners the lead for this. The aim being to work with young mothers, in particular teenage mothers, to discuss and offer support to them whilst pregnant and after they gave birth to their child.
- The practice was a member of the local education and skills partnership and were engaging with a local primary school to make a health promotion video, therefore increasing the awareness of good health to children.

Bridgegate Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, and a specialist advisor with experience of GP practice management.

Background to Bridgegate Medical Centre

The area covered by Bridgegate Medical Centre is predominantly the south of Barrow-in-Furness and the surrounding villages. The practice provides services from the following address and this is where we carried out the inspection, Winchester Street, Barrow in Furness, Cumbria, LA13 9SH.

The surgery is modern and purpose built. The facilities are on the ground floor with disabled access and a car park.

The practice has four GPs partners, three salaried GPs and one GP registrar (a fully qualified doctor allocated to the practice as part of a three-year, general postgraduate medical training programme), Six of the GPs are female and two male. The practice is a training practice. There are three practice nurses, one health care assistant and a phlebotomist. There is a practice manager, office manager, administration manager and 16 reception and administrative staff.

The practice provides services to approximately 8,700 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) Agreement with NHS England.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Cumbria Health on Call (CHOC).

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

We carried out an announced visit on 7 May 2015. During our visit we spoke with a range of staff. This included GPs, practice nurses and reception and administrative staff. We also spoke with eight patients. We reviewed two CQC 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

As part of our planning we looked at a range of information available about the practice from the National GP patient survey and the Quality Outcomes Framework (QOF), which is a national performance measurement tool. The latest information available to us at the time of the inspection indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as comments and complaints received from patients. For example, it was found that a patient had been given an incorrect vaccine. The incident was recorded and lessons were learned; further training and advice was given to staff.

Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We reviewed safety records, incident reports and minutes of meetings. These showed the practice had managed these consistently over time and so could demonstrate 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. They were open and transparent when there were near misses or when things went wrong. There were records of significant events dating back to 2002 and we were able to review these. The GPs and practice manager told us that significant events were discussed as soon as practicable, usually at the weekly practice meeting We saw this was a standing item on the agenda and minutes of events which were held. Following the meeting, an action plan was drawn up including what had occurred, learning points and feedback from the review and any action taken which was necessary.

Staff could describe recent significant events and identify the learning they had taken from them. Receptionists, administrators and nursing staff we spoke with knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts came to the practice via email. The practice manager had responsibility to disseminate patients safety alerts to the most appropriate member of staff in the practice, they used a spreadsheet to assist with this process. The practice manager would then ensure the appropriate staff read them. Safety alerts which involved medicines were disseminated by the medicines manager at the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. They met with health visitors on a quarterly basis to discuss child safeguarding issues. Safeguarding issues and children at risk were discussed at the weekly practice meeting as a standing agenda item. The practice had a dedicated GP appointed as the lead for both safeguarding vulnerable adults and children. This GP was responsible for ensuring staff were aware of any safeguarding cases or concerns. They had been trained to level 3 for safeguarding children and other staff had been trained to the appropriate level for their role, practice training records confirmed this.

Staff were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Staff we spoke with said they knew which of GP partners was the safeguarding lead. Contact details were easily accessible for the local authority safeguarding department.

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out).

The practice had a chaperone policy. A notice was displayed in the patient waiting areas to inform patients of their right to request a chaperone. The practice manager told us it was mainly clinical staff who acted as chaperone. Although some administrative staff were trained to act as chaperone if required and had received the appropriate vetting checks.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored

securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, this described the action to take in the event of a potential failure. Stock control of medicines was managed by the practice nurses. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

However, blank computer generated prescription forms were not handled according to NHS protect guidance. The practice did not have measures in place to maintain the security of the forms when the printer was left unattended or the consulting rooms were not in use.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that the patient's repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

We saw the practice was clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities.

The practice nurse was the nominated infection control lead and received training in infection control. We saw there was an up-to-date infection control policy and detailed guidance for staff about specific issues such as needle stick injuries. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies on the shared computer drive. There were yearly audits of infection control and hand hygiene. Staff had received infection control awareness training and the practice nurse trained them in how to handle specimens.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. The infection control lead nurse told us the privacy curtains in the consultation rooms were cleaned every six months however; there were no dates recorded on the record or dates recorded on the curtain as to when they were last cleaned. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice employed their own cleaning staff. There were cleaning schedules in place for use by the cleaners. The practice manager carried out regular checks to ensure these were being followed.

An external contractor had carried out a legionella (bacteria found in the environment which can contaminate water systems in buildings) risk assessment. This confirmed no further action was necessary because the practice did not have water based cooling systems from which legionella would be produced.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments which was appropriate for patient's needs. The practice had a range of equipment in which included medicine fridges, patient couches, a defibrillator and oxygen, sharps boxes (for the safe disposal of needles) and fire extinguishers. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. Staff recruitment records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body.

We discussed criminal records checks which are made via the Disclosure and Barring Service (DBS) with the practice manager. All clinical staff had received a DBS check and non-clinical staff other than the apprentice receptionists. There was a documented risk assessment as to why they had not received a DBS check.

Staff told us there were enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. The practice manager explained the system for covering for absences. For administration staff there was a rota system split into mornings and afternoons and they

Good

Are services safe?

knew how many staff they needed to cover. The GPs had a shared calendar for absences, no more than two GPs could be absent at any one time and they would provide cover for each other. We asked if the practice used locum cover and were told this had not been necessary since 2012. The practice nurses were part time and covered each other's absences. The GPs had been aware of higher demand for appointments in 2014 and with planning and increased GP sessions they were able to improve the number of GP appointments by 26.75% over the year.

We saw an example of vetting for GP registrars who worked at the practice. This included identity and DBS checks and records of professional qualifications. There was also an induction package available for GP registrars.

There were induction packages for different job roles within the practice, for example, we saw copies of inductions for locum GPs and for administration staff and these were specific to the various job roles.

The practice manager carried out checks to ensure that clinical staff had up to date registration with professional bodies such as the Nursing and Midwifery Council (NMC). There was also a log of medical indemnity insurance for clinical staff and the date it was due for renewal.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy. However, there was no health and safety risk assessment. The practice manager was the nominated safety officer and the health and safety policy stated the safety officer should conduct regular inspections of the workplace and maintain safety records which would include a health and safety risk assessment.

The practice manager showed us the fire risk assessment which had been carried out in 2013 and actions from this had been addressed. Staff had received fire training and there were two nominated fire wardens. However, staff told us and the practice manager confirmed there had been no fire evacuation drill for over 12 months. We saw records confirming the fire alarms and emergency lights were regularly tested.

The practice had developed lines of accountability for all aspects of patient care and treatment. The GPs and had lead roles such as palliative care and safeguarding for clinical issue and non-clinical responsibilities such as access to patient services and nursing services.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with regarding emergency procedures knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The defibrillator and oxygen were accessible and records of weekly checks were up to date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Copies of the plans were held by the practice manager and GPs at their homes and contact details were available if the buildings were not accessible.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

All clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. New guidelines and the implications for the practice's performance and patients were discussed at weekly clinical meetings.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. Recall appointments were aligned to the patients birthday month and a holistic review of the patient's long-term conditions would be carried out in one appointment where possible. Patients with diabetes received six monthly checks. The health care assistant managed the recall register. High risk patients with long term conditions were included in care planning and had a named GP.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. We saw the practice had achieved a score of 100% of the percentage points available to them for providing recommended treatments for the most commonly found clinical conditions. This was above both the local clinical commissioning group (CCG) by 5.1 percentage points and England averages by 6.5 percentage points.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for clinical audit. We saw nine clinical audits had been carried out in the last year. There was however only one example of a two cycle clinical audit in relation to cancer diagnosis. A two cycle audit is an audit which has been repeated using same methodology to demonstrate that changes from the first audit have been implemented and that improvements have been made. The GPs told us that audits were currently on going and they hoped to have more completed two cycle audits in the future.

The practice used the information collected for the QOF and performance in national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with diabetes for known risk factors. The practice met all the minimum standards for QOF in the management of long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy.

The practice made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records. We saw that all staff had received training such as basic life

Good

Are services effective?

(for example, treatment is effective)

support, fire safety, safeguarding children and adults, infection prevention and information governance. Some staff had received additional training such as dementia awareness and customer service training.

All GPs were up to date with their yearly continuing professional development requirements and all had either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list). Salaried GPs were informally appraised by the practice annually to ensure they received support.

The practice manager explained the process for staff appraisal. Staff received a pre-appraisal form to complete before they had their appraisal meeting. We saw examples of staff appraisals which administration staff had received in October 2014. The practice nurses received an appraisal jointly carried out by the practice manager and a GP. The practice manager was not formally appraised, however, they said they felt supported and had open access to the GPs.

Working with colleagues and other services

The practice could demonstrate that they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held multidisciplinary team meetings every quarter, minutes were made available to us. This included meetings regarding child protection and palliative care. These meetings were attended by the practice's GPs and nurses along with district nurses, social workers, community psychiatric nurses, drug and alcohol workers and palliative care nurses depending upon the meeting.

The practice received a list of unplanned admissions and attendance at accident and emergency (A&E) to support them to monitor this area. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the NHS 111 service, were received both electronically and by post.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

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

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the GPs were aware of the MCA and used it appropriately. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out

Good

Are services effective?

(for example, treatment is effective)

first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

New patients were required to complete a registration form and questionnaire and then make an appointment with the health care assistant for a new patient health check.

Information on a range of topics and health promotion literature was available to patients in the waiting areas of the practice. There was a dedicated information board with information on the local carer's association and dates a support worker would be in the practice to hold clinics to support carers. There was information on the practice website regarding family health, long term conditions and minor illness and health clinics. The practice offered a range of health clinics which included; travel vaccines, flu vaccines, family planning, cervical screening and NHS health checks for those aged between 40 and 75.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data showed the practice had obtained 100% of the points available to them for providing support with smoking cessation. This was 5.7 percentage points above the local CCG average and 6.3 points above the England average. The data also showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages.

The practice offered baby and anti-natal clinics. A full range of immunisations for children, in line with current national guidance were offered. Last year's performance for immunisations was slightly below or in line with the averages for the clinical commissioning Group (CCG). For example, infant meningococcal C (Men C) vaccination rates for two year old children were 94.8% compared to 97.9% across the CCG; and for five year old children were 96.6% compared to 96.6% across the CCG.

The practice had set up a maternity services liaison group with one of the GP partners the lead for this. The aim being to work with young mothers, in particular teenage mothers, to discuss and offer support to them whilst pregnant and after they gave birth to their child. An issue identified from this group was that young mothers felt isolated whilst in hospital. They were unaware that Wi-Fi was in the local hospital which the hospital was then able to advertise for young mothers to use.

The practice was a member of the local education and skills partnership and were engaging with a local primary school to make a health promotion video, therefore increasing the awareness of good health to children.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey. For example, the proportion of patients who described their overall experience of the GP surgery as good or very good was 91%, which was above the clinical commissioning group (CCG) average of 89%. The proportion of patients who said their GP was good or very good at treating them with care and concern was 90%, the CCG average was 89%. The proportion of patients who said the nurse was good or very good at treating them with care and concern was 94%, the CCG average was 94%.

In the practice's own survey of 2014 patient feedback included;

- Patients said they were completely or very satisfied with the overall service from the practice – 77.5% (22.5% were fairly satisfied with no negative responses).
- How well did the doctor put the patient at ease during the consultation – 97.8% rated this as excellent or good.
- The doctor listened to patients – 92.9% rated this as excellent or good.

We spoke with eight patients on the day of our inspection; this included two members of the patient participation group (PPG). All of the patients were satisfied with the care they received from the practice and said their dignity and privacy was respected. They found staff helpful and friendly. Patients commented that they thought they received a good service from the practice.

The practice's own patient survey gave feedback on the reception staff. 92.9% of patients thought they were treated positively by the staff. The GP national survey data showed 98% of patients found the receptionists helpful, the CCG average was 92%.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

Care planning and involvement in decisions about care and treatment

Patients told us they felt listened to by the GPs and practice nurses. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

From the 2015 National GP Patient Survey, 86% of patients said the GP they visited had been good at involving them in decisions about their care (CCG average was 86%). The data showed that 91% of patients said the practice nurse they visited had been good at involving them in decisions about their care (CCG average 90%).

The practice's own survey gave feedback on how much patients thought the doctor had involved them in decisions about their care, 90.2% of patients rated this as excellent or good.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice's computer system alerted GPs if a patient was also a carer. There was support available for carers from the local carer's support group.

There was a palliative care register and regular contact with the district nurses. There were quarterly palliative care meetings which involved GPs, district nurses and palliative care nurses. Palliative care was also a standing agenda item on the weekly practice meeting agenda.

Staff told us that if families had suffered bereavement there was support available. A card of condolence would be sent to the family which also asked them to contact the practice if they needed any help. The GPs would carry out a home visit if needed.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were taken in to account. Most of the GPs and many of the staff had worked at the practice for many years which enabled good continuity of care.

All patients aged over 75 had been notified of their named GP. High risk groups of elderly patients, such as those receiving palliative and residential care had care plans in place. Two of the GPs had completed diplomas in palliative care and another a diploma in geriatric medicine. Patients experiencing dementia received annual reviews and the practice had a dementia diagnosis rate of 85%, the CCG average was 54%. The practice had a palliative care register which was a standing agenda item at the weekly practice meeting and there were quarterly palliative care multi-disciplinary meetings.

For over 15 years the housebound patients and patients in nursing or residential care received their flu vaccines in September or October, the practice nurse used this opportunity to carry out reviews of long-term conditions and take blood tests at the same time.

The practice carried out annual health reviews of patents with learning disabilities. There was a GP lead for adult safeguarding and any vulnerable patients needing support were included on the 'one to watch' list which was discussed at the weekly practice meeting.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the practice PPG. The group had helped the practice by giving feedback to the considerations of the implementation of extended access to appointments. They also influenced improvements to the repeat prescription process.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services, including sign language, if required.

The practice worked closely with mental health services. Referrals were made to counselling and organisations such as MIND. Patients experiencing poor mental health received annual health reviews. Drug and alcohol workers offered an open access service to patients at the surgery.

All of the treatment and consulting rooms could be accessed by those with mobility difficulties; however the front door the surgery was heavy to open. The practice had located a bell outside in case a patient needed to gain assistance to open the door. The patient toilets could be accessed by patients with disabilities and there were designated disabled parking spaces in the surgery car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties.

The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP.

Access to the service

Patients we spoke said they found it easy to obtain an appointment, there was no problem with making an urgent appointment and the waiting time for routine appointments was usually no longer than a week. The National GP Patient Survey 2015 showed patient satisfaction was in line with the local averages, 76% of patients said their overall experience of making an appointment was very good or fairly good (CCG average 78%).

The appointment times at the practice were between 8.30am and 12 noon, 3:30pm to 5:50pm Monday and Friday, 7:30am and 12 noon, 3:30 to 7:00pm Tuesday to Thursday. Appointments were bookable up to three months in advance, with some bookable on-line. 20% of appointments were embargoed for on the day emergency appointments. Telephone appointments and home visits were available. The practice had "pink card" appointments which were specifically held back at times suitable for children after school.

We looked at the practice's appointments system in real-time on the day of the inspection. At that time there were on-line routine appointments available the following Monday which was two working days away and the next bookable routine appointment was in three working days, the following Tuesday.

Information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments

Good

Are services responsive to people's needs?

(for example, to feedback?)

and home visits. There was also a leaflet regarding the practice's patient charter which set out the services patients could expect to receive. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice offered appointments and repeat prescriptions on-line. Repeat prescriptions could also be ordered via post or at reception.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Information regarding how to make a complaint was in a leaflet named complaints procedure, this leaflet signposted patients to a complaints form which was available at reception.

The practice manager supplied us with a schedule of three complaints which had been received in the last 12 months. We looked at the response to them and found these had all been dealt with in a satisfactory manner. Complaints were discussed at the weekly practice business meeting if any were received that week and then reviewed annually.

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 provider had a vision to provide high quality healthcare in a traditional family practice, whist embracing the challenges necessary to meet changes in patient expectation and contractual obligation, and adhering to their core values of openness, fairness, respect & accountability. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. The practice were aware of what they did well, for example, their QOF achievements. They were continually improving patient access and what areas they needed to monitor, for example patient numbers were increasing.

The practice recognised that there were many changes and challenges to general practice which they needed to discuss and address. In October 2013 they had an away day of the partners and senior management team to discuss priorities and to review the practice business plan. There was an action plan produced which defined the practice priorities such as appointments and demand and the refurbishment of the premises and where the practice were with progress for these actions. The practice manager was then invited by the CCG to present to other practices how the practice had prioritised areas of change and the work they had carried out on this.

One of the priorities was to produce a monthly newsletter for staff giving them information on what was happening in the practice such as updates on extended surgery opening hours and future staff events.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date.

The practice used QOF data to manage performance; they were performing above the averages of the local CCG and across England as a whole. The practice had identified clinical leads for many of the QOF areas, for example diabetes or chronic obstructive pulmonary disease (COPD). There was a system in place for clinical audit, although not always two cycle audits, which was also used to improve outcomes for patients.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles including non-clinical areas. For example, there was a lead GP for safeguarding, prescribing, finance and IT. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held regular staff, clinical and practice meetings. In particular, a weekly practice meeting where the practice manager, nursing staff and GPs attended. The practice held practice meetings every month with staff in protected learning time. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed.

Five of the seven current GPs had been GP registrars with the practice and had chosen to stay and work at the practice. The practice were succession planning for future retirements of GPs and had salaried GPs in line to replace the partners once they retired.

The practice had put themselves forward to provide placements for nurse training from a local university. This was to provide mentorship and nursing placements for third year nursing students and the practice hoped this would give them greater insight into practice nursing and encourage student nurses to become practice nurses.

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

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us they attended staff meetings. Staff said this gave them the opportunity to give feedback and raise any concerns they had.

The practice had a patient participation group (PPG) which had been established approximately four years. This consisted of nine patients who met every six months, we saw minutes of the last meeting in March 2015, where a review of the previous year was undertaken. We spoke with two members of the group who said they felt involved in giving their views and these were taken seriously.

Are services well-led?

Good

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

A practice survey was carried out in 2014. The survey was based around similar questions to the GP National Patient Survey.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw staff were supported to develop through regular training, supervision and appraisal. Staff told us that the practice was supportive of their training needs.

We saw practice staff met on a regular basis. Staff from the practice also attended the clinical commissioning group (CCG) protected learning time (PLT) initiatives. This provided staff with dedicated time for learning and development. There was also in house protected learning time.