Drayton Medical Practice

Quality Report

Market Drayton Primary Care Centre
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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 12 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the effective, caring, responsive and well-led domains, and requires improvement in the safe domain. We found the practice provided outstanding care to people experiencing poor mental health and good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired and people in vulnerable circumstances.

Our key findings were as follows:

- The appointment system was responsive to the needs of the patients. This ensured patients were able to access same day and emergency appointments.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at treating them with care and concern.
- Staff were all clear about their own roles and responsibilities, and felt valued, well supported and knew who to go to in the practice with any concerns.

We saw several areas of outstanding practice including:

- The practice offered a range of in house services for people with poor mental health, and worked closely with the community mental health teams.
- Patients could access a minor injury clinic held at the practice every week day.
- The practice had battery packs on standby for the vaccine refrigerators to ensure power was maintained if the electricity supply was interrupted.

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

The provider should:

Summary of findings

- Ensure chaperone policy is revised to reflect safe practice and all staff are made aware of the revised policy.
- Have a system to check stock levels and audit to ensure all medicines remain in date and safe to use.
- Replace the oxygen cylinder.
- Obtain all required employment checks prior to employment of all new staff.
- Complete an annual audit for 2014 for minor surgical procedures.
- Develop and implement a business continuity plan.
- Ensure all meetings are minuted and the minutes shared with all staff.
- Review and update all policies and procedures, including review dates.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not detailed enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. The practice did not have a system in place to check stock levels or audit to ensure all medicines remained in date and safe to use. Staff were not recruited in accordance with the practice's own recruitment and selection policy. The practice did not have a business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good access to the practice, and confirmed that they were usually offered a same day appointment when they telephoned, and could also

Summary of findings

book appointments in advance. The practice had good facilities and was well equipped to treat people and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them. There were a range of clinics to provide help and support for patients with long-term conditions.

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, but these were overdue a review. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. The practice had identified vulnerable older patients and had developed individual care plans to support their care needs. These care plans were shared with the out of hours provider, with patients' permission. Influenza and shingles vaccinations were offered to older patients according to national guidance. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Named GPs were responsible for care of patients in care homes, and carried out weekly visits to a number of care homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competencies to respond to the needs of patients with a long term condition such as heart disease and asthma. The nursing staff were supported by lead GPs for each long term condition. The practice maintained registers of patients with long term conditions. Individual care plans had been developed to support their care needs. We found robust systems in place to ensure that all patients with a long term condition received regular reviews and health checks at a time suitable to them. Staff were proactive in following up patients who did not make appointments for their reviews.

Families, children and young people

Good

The practice is rated as good for families, children and young people. We saw that the practice provided services to meet the needs of this population group. Urgent appointments were available for children who were unwell. Staff were knowledgeable about how to safeguard children from the risk of abuse. Systems were in place for identifying children who were at risk, and there was a good working relationship with the health visitor attached to the practice. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. The premises were suitable for children and babies, with a designated play area. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Information was available to young people

Summary of findings

regarding sexual health and family planning advice was provided by staff at the practice. New mothers and babies were offered an integrated six week check, at which they saw the GP, practice nurse and health visitor. Antenatal clinics were also held at the practice.

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 practice offered a range of appointments which included on the day and pre-bookable appointments, as well as telephone consultations. The practice was pro-active in offering on line services as well as a full range of health promotion and screening services which reflected the needs of this age group. The practice offered all patients aged 40 to 74 years old a health check. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice.

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. We found that the practice enabled all patients to access their GP services. Staff told us that they supported a local travelling community, people who lived on nearby narrow boats, people with substance misuse, and families stationed at the local barracks. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for people experiencing poor mental health (including people with dementia). An example of outstanding practice is that the lead GP for mental health ran a two weekly clinic for patients with severe mental health needs, as well as visiting patients at home. These patients were offered longer appointments and the majority had individual care plans in place. Good working relationships were in place with other services for people with mental health needs, for example the Primary Care Liaison Service. GPs were able to make appointments for patients directly with the service, and patients were usually seen within one

Summary of findings

or two weeks. The practice worked closely with the Community Substance Misuse Team, and provided shared care for patients requiring methadone prescriptions. Referrals were also made to Child and Adolescent Mental Health Services (CAMHs) to provide support for children experiencing poor mental health.	

Summary of findings

What people who use the service say

We spoke with 12 patients on the day of the inspection. Patients were generally satisfied with the service they received at the practice. Patients spoken with told us there were no issues with same day appointments, although they may wait up to four weeks for a pre bookable appointment with a specific GP.

We reviewed the 31 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and approachable. They said the staff listened and responded to their needs. Three patient comment cards were less positive, and the comments were mainly about the appointment system: the length of time between booking and attending a pre-bookable appointment, length of time waiting to be seen when at the practice and having to give some information to reception staff for the triage system.

We looked at the national GP Patient Survey published in December 2013. The survey found that 79% of patients described their overall experience of Drayton Medical Practice as good or very good, which was lower than the local Clinical Commissioning Group average. In addition, 67% of patients would recommend the practice to someone new to the area, which was also lower than the local Clinical Commissioning Group average.

Areas for improvement

Action the service SHOULD take to improve

Ensure chaperone policy is revised to reflect safe practice and all staff are made aware of the revised policy.

Have a system to check stock levels and audit to ensure all medicines remain in date and safe to use.

Replace the oxygen cylinder.

Obtain all required employment checks prior to employment of all new staff.

Complete an annual audit for 2014 for minor surgical procedures.

Develop and implement a business continuity plan.

Ensure all meetings are minuted and the minutes shared with staff as appropriate.

Review and update all policies and procedures, including review dates.

Outstanding practice

The practice offered a range of in house services for people with poor mental health, and worked closely with the community mental health teams.

Patients could access a minor injury clinic held at the practice every week day.

The practice had battery packs on standby for the vaccine refrigerators to ensure power was maintained if the electricity supply was interrupted.

Drayton Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience, who had personal experience of using primary medical services.

Background to Drayton Medical Practice

Drayton Medical Practice is a purpose built, primary care medical centre located in Market Drayton. Drayton Medical Centre serves the local population by providing general medical services. All clinical rooms and treatment rooms are located on the ground floor.

The practice has nine GP Partners and one salaried GP (seven male and three female), three GP registrars, a practice manager, seven practice nurses, two healthcare assistants, three phlebotomists and reception and administrative staff. There are 17201 patients registered with the practice. The practice is open from 8.30am to 6pm Monday to Friday. The practice treats patients of all ages and provides a range of medical services. Drayton Medical Practice has a higher percentage of its practice population in the 65 and over age group than the England average.

The practice provides a number of clinics for example long term condition management including asthma, diabetes and high blood pressure. It offers child immunisations, minor surgery and travel health. The practice also provides a minor injury service Monday to Friday and mental health clinics every two weeks.

Drayton Medical Practice has a General Medical Services contract.

The practice is a training practice for GP Registrars to gain experience and higher qualifications in General Practice and family medicine. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

Drayton Medical Practice does not provide an out of hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

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

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

Before carrying out our inspection, 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 12 November 2014. During our inspection we spoke with two GPs, one GP Registrar, two practice nurses, the practice manager, the reception manager, the management assistant, the information technology lead and a spokesperson from the Patient Participation Group (PPG). We spoke with twelve patients who used the service about their experiences of the care they received. We observed how patients were cared for. We reviewed 31 comment cards where patients and members of the public shared their views and experiences of the service. Following our inspection we spoke with representatives from two care homes where Drayton Medical Practice provided care and treatment to several of their patients.

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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report significant events and near misses. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant event meetings were held every quarter. However, the minutes did not include details of actions to be taken, by whom and when. Previous significant events were reviewed at the next meeting. There was evidence that the practice had learned from significant events and the learning points were included in the minutes. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. However, although representatives from each department attended these meetings, there was no system in place to disseminate the minutes to non attendees. The practice did not carry out an annual review of all significant events to identify any trends or themes.

Staff used paper incident forms and sent completed forms to the practice manager. They showed us the system they used to manage and monitor incidents. The action taken and learning from significant events was recorded in the meeting minutes. For example, a patient had attended the practice with a foreign body in their eye. Nursing staff were unable to locate the local anaesthetic drops when requested by the GP, resulting in the patient being referred to the hospital. As a consequence, a list of eye drops available in the practice and their location had been drawn up and made available to clinical staff.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with described the action they would take for alerts that were relevant to the care they were responsible for. They also told us alerts were actioned by specific staff, the acting nurse manager was responsible for checking equipment, to ensure that action had been taken where required.

Reliable safety systems and processes including safeguarding

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

The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children who could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans, patients who lived in care home and patients on the disease registers.

Information about a chaperone service was in place and visible around the practice. Patients spoken with told us they were offered a chaperone when an examination was being carried out. Nurses and reception / administration staff acted as chaperones when requested by the GP. Not all staff had received formal chaperone training. Those staff who had received training commented that the guidance on where to stand in the online training programme

differed from the guidance in the policy. Staff followed the policy when acting as chaperones and did not stand in a position where they would be able to observe the examination.

Patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system, Vision, which collated all communications about a patient including electronic and scanned copies of communications from hospitals. Appropriate codes were being used on the electronic case management system to identify vulnerable patients. Staff told us there were alerts to notify them about vulnerable patients.

The practice worked with other services to prevent abuse and to implement plans of care. Staff told us that although formal meetings did not take place the health visitors were located in the same building. This provided the opportunity to discuss any concerns as they arose, for example, a child not attending for their immunisations. Staff told us a system was in place to refer any child they had concerns about either to the health visitor or school nurse depending on the child's age. Community staff, such as health visitors and district nurses could access patient notes via the electronic system.

Medicines management

We checked medicines stored in the treatment rooms, store cupboard and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. The practice had battery packs on standby for the vaccine refrigerators to ensure power was maintained if the electricity supply was interrupted.

We found that medicines were administered and stored correctly. We were told there was a designated member of staff responsible for managing the medicines held in the practice. We checked the storage and stock control of the medicines held in the practice. We found that medicines were well organised and kept in locked cupboards. However we found that an oxygen cylinder had expired at the end of 2012.

We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This covered how changes to patients' repeat medicines were managed and authorisation of repeat prescriptions. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

All of the patients we spoke with during the inspection told us that the practice was always clean and tidy. They told us they had observed staff using hand gel during consultations. We saw that the practice was clean and orderly. We saw there were cleaning schedules in place and cleaning records were kept.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Staff received training about infection control specific to their role. The infection control lead told us they attended infection control meetings organised by the Clinical Commissioning Group (CCG). Information was disseminated to clinical staff via team meetings and in the protected learning time sessions.

An infection control audit completed by the local CCG in October 2014 had identified a small number of issues that required addressing. We saw there was a completed action plan in place to address these issues. The infection control lead also carried out 'check to protect' audits on different aspects of infection control every six weeks.

Requires improvement

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff confirmed they used single use equipment for most procedures. Staff told us that items that were not single use, for example the cuff used on 24 hour blood pressure machines, were laundered between patients.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that relevant staff had received the appropriate immunisations and support to manage the risks of health care associated infections.

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

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, thermometers, medical scales and blood pressure monitors.

Staffing and recruitment

Recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw a recruitment policy outlining the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. We looked at five staff files, of which two members of staff had been employed recently. We saw that not all of the appropriate checks had been carried out. For example, proof of identification and a photograph were missing in one file, and satisfactory evidence of conduct in previous employment missing in the other. The practice had used the Disclosure and Barring Service (DBS) from the current employer for a member of bank staff. Neither file contained complete employment histories, as there were gaps in employment and start and finish dates were not always included for employment.

The registered manager and practice manager told us that the staffing structure was under review. They had recognised the need for additional staff in certain areas, for example phlebotomy (blood taking), and that administration staff needed to be able to undertake multiple roles. The practice manager told us they were looking to develop existing staff although recognised they would need to recruit additional staff. The practice manager told us the appointment of the additional staff would provide additional resilience to cover holidays and sickness. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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 weekly fire alarm checks, medicines management, and dealing with emergencies and equipment. The practice also had a health and safety policy. Staff told us they could access the policies and procedures on the computer and paper copies were also available.

A risk assessment of the building had been completed by the contract cleaners. This included slips, trips and falls, electric shocks and lone working. Identified risks were included on a risk log. The practice manager told us that the risk assessments and policies were reviewed on an annual basis. Any changes or updates were discussed at the risk assessment meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: the practice had identified patients who were at high risk of admission, as well as those with long term conditions, dementia, mental health needs and learning disabilities. Individual care plans had been developed for the majority of these patients. The aim of this was to reduce the amount of unplanned admissions to hospital.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. However, we found that the oxygen cylinder had expired at the end of 2012.

The practice did not have a business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs told us that any new information was discussed informally at the clinical meetings. However there was no formal process for discussing and implementing NICE guidelines. The acting nurse manager told us there was direct link to the local Clinical Commissioning Group (CCG) guidelines on the computer. They said the patient group directions (PGDs) for vaccines had recently been updated, and the information had been shared with the nursing team. They also told us they had recently updated their treatment plans for asthma following changes to guidance from the British Thoracic Society.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, respiratory disease and mental health. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Due to the recent changes in staff, two GPs carried out the reviews for patients with diabetes and cardiovascular disease. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The practice had identified patients with long term conditions and had developed individual care plans to support patients to ensure their care needs were met and avoid unnecessary hospital admissions.

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 ethnicity was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess its performance. The QOF rewards practices for providing quality care and helps to fund further improvements. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice achieved 99 QOF points, which is higher than the national average. This practice did not fall outside the normal range for any QOF (or other national) clinical targets.

The GPs told us that audits were usually triggered by a significant event or an individual GP's interest. The practice showed us four clinical audits undertaken in the last three years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The other three audits were ongoing and required a second set of data collection during 2015. For example: the practice carried out an audit of the recording of home visits in patient notes during 2012 – 2013. The full audit cycle was completed and demonstrated an improvement in the recording of home visits. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. However, the last audit available and seen on the day of inspection was dated 2010 - 2011.

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. We saw there was a robust system in place for medicine reviews. Patients spoken with told us their medicines were regularly reviewed by the GPs.

The practice had achieved and implemented the gold standard framework for end of life care. It had a palliative care register with each patient having a care plan in place. Each patient on the register had a named GP. Multidisciplinary meetings were held quarterly 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 and saw that all staff had attended training courses such as annual basic life support and safeguarding vulnerable adults and children. All GPs were up to date with their yearly continuing professional development requirements and all have been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called

Good

Are services effective?

(for example, treatment is effective)

revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and developing staff. For example, the practice had identified that with additional training, the health care assistants would be able to carry out simple nursing tasks. The acting nurse manager told us the practice nurses were assessed using the Royal College of General Practitioners (RCGP) General Practice Nurse Competencies. This supported staff to identify any training needs. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out of hours GP services and the 111 service both electronically and by post. Each GP reviewed information from other services about their patients. The GP who saw these documents and results was responsible for the action required. Systems were in place to ensure that patient information was reviewed when GPs were on leave. The practice used an electronic system for document management (Docman). This system enabled documents to be scanned onto the electronic system and then allocated to the named clinician or trainee. Required actions were recorded on the electronic system and passed on to the relevant person to action. For example, if results were abnormal, this was recorded so that reception staff could inform patients they needed to make an appointment when they contacted the surgery.

A number of other services were also located in the same building as the practice, for example, community nursing staff including district nurses, health visitors and midwives. Staff told us that although the health visitors and midwives did not attend multidisciplinary meetings, they had good working relationships with them. Staff told us the health visitors and midwives had access to the computer system, and recorded information in the patients' notes.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record Vision, to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The registered manager told us that they were able to access Vision when visiting patients in one of the care homes they visited. This enabled the GP to access any results and update the patient record during the visit. The practice was looking to extend this service to all care homes

The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them. Information from the GP to the specialist was dictated and typed by the secretaries within 24 hours. Urgent suspected cancer referrals were completed immediately. Patients were informed to contact the practice if they did not receive an appointment within two weeks.

A number of staff had done training about information governance to help ensure that information at the practice was dealt with safely with regard to patients' rights as to how their information was gather, used and shared.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act 2005, and assessment of Gillick competency of children and young adults, and information around the Fraser guidelines. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

The GPs spoken with told us that all staff completed online training on the Mental Capacity Act 2005. However, this was

Good

Are services effective?

(for example, treatment is effective)

not reflected in the training records. They also told us that an external speaker had attended a staff meeting previously to discuss capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Staff spoken with told us if they had any concerns about a person's capacity to make decisions, they would ask a GP to carry out an assessment.

We saw examples that supported the GPs had sought the patient's consent to certain decisions, for example, do not attempt resuscitation care plans. We saw that the appropriate paperwork had been completed. One GP partner was the lead for mental health, and provided advice and guidance on restraint and best interest decisions. There was a practice policy for documenting consent for specific interventions. For example, for all invasive procedures written consent from the patient was obtained.

Health promotion and prevention

When registered at the practice new patients were required to complete a questionnaire providing details of their medical history. They were also invited to book an appointment with one of the health care assistants for a new patient health check. The practice also offered the NHS health checks to all patients aged 40 to 74.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations and smoking cessation (referral to service). Patients told us they were asked about their lifestyle by the clinical staff, and healthy eating and exercise were discussed. We were also told that the practice carried out child immunisations and offered family planning advice and support, including emergency contraception. A range of leaflets were available in the waiting room.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was generally in line with the average for the local clinical commissioning group.

Flu vaccination was offered to all over the age of 65, those in at risk groups and pregnant women. The percentage of eligible patients receiving the flu vaccination was above the national average. The shingles vaccine was offered according to the national guidance for older people.

One of the practice nurses we spoke with told us that health promotion information was available for all patients. They told us that they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. They also told us when patients attended the minor injury clinic, the nursing staff assessed them to see whether they needed to be referred to specific clinic for ongoing heath checks.

The practice had numerous ways of identifying patients who needed additional support, and were proactive in providing additional help. For example, the practice kept a register of all patients with learning disabilities and patients were offered an annual physical health check.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in December 2013, a survey of 462 patients undertaken by the practice's patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed that the practice was rated amongst the worst for patients rating their overall experience of their GP practice as good or very good, even though the score was 79%. The survey showed that 89% patients felt that the doctor was good at treating them with care and concern, which is above the Clinical Commissioning Group (CCG) area average. 95% of the patients who responded said that they had confidence and trust in the doctor they had seen last at the practice, which is above the Clinical Commissioning Group (CCG) area average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 31 completed comment cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and approachable. They said the staff listened and responded to their needs. Three patient comment cards contained comments that were less positive, and the comments were mainly about the appointment system: the length of time between booking and attending a pre-bookable appointment, length of time waiting to be seen when at the practice and having to give some information to reception staff for the triage system.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in the consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations. We noted that consulting / treatment room doors were closed during consultations and that conversations taking place could not be overhead. We observed staff knocked on closed doors and waited to be invited in before entering.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. A notice was in place requesting that only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Seating in the waiting rooms was located well away from the reception desk.

There was information on the practice's website stating the practice's zero tolerance for abusive behaviour. We saw that staff attended conflict resolution training, to help them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff and were given sufficient time during consultations to discuss any concerns. One patient told us the GP had given them a good explanation about their condition, and they were given the opportunity to ask questions. Patient comments on the comment cards we received were also positive and supported these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 83% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above the average compared to the CCG area average.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. They also told us one member of staff spoke Polish and had received specific training so they could act as a translator.

The practice maintained registers of patients who were vulnerable because of their disability or medical condition. There were 55 patients on the practice's learning difficulties register and care plans had been developed for 29 of these patients. Staff told us that annual health reviews were carried out for patients with learning difficulties and care plans developed following the review. We saw that everyone identified on the practice's register for patients with mental health difficulties had a care plan in place. Patients with long term conditions which included patients with coronary heart disease; diabetes; chronic obstructive pulmonary disease and asthma were identified on the electronic patient record. We saw that there was a system in place that ensured patients received an annual health review. The Quality and Outcomes Framework (QOF) data that we reviewed showed that the percentage of patients diagnosed with dementia who had received a review of their care in the previous 15 months was in line with national standards.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 89% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern with a score of 87% for nurses. Both of these results were above the CCG area average. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients described the care they received as good.

Notices in the patient waiting room told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Patients nearing the end of their life had their care and support reviewed at quarterly multidisciplinary meetings which included practice staff, district and palliative care nurses. Staff told us that the GPs visited families following bereavement.

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 understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had identified that the nearest accident and emergency unit was over 20 miles away. As a result, the practice provided the additional service of a minor illness and injury clinic five days a week, to provide care closer to home. The practice also provided a mental health clinic every two weeks for patients with severe mental health illness and / or a learning disability.

The practice used a range of risk assessment tools to identify vulnerable patients. The practice was monitoring the risk of unplanned admissions and had developed individual care plans for patients. Patients identified as requiring end of life care had a named GP and were given priority for appointments.

One of the GP partners and the practice manager attended locality meetings. These provided the practice with an opportunity to discuss any issues, for example: the development of the Integrated Care Team.

We spoke with the managers from two local care homes. They told us they worked in partnership with the practice to meet the needs of the patients. The practice visited the care home every week to review patients who required a GP visit. Staff said that between the weekly visits, they could telephone the practice for guidance, or to request a visit. One manager told us that when the named GP was on leave, the other GPs were reluctant to visit outside of the set visiting day. They also told us they felt the system for repeat prescriptions was not as organised as it could be. However, they had spoken with the practice about this and were reassured their concerns had been listened to. The practice also cared for patients in other care homes, and these patients were seen by the GPs on request.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, a local travelling community, people who lived on nearby narrow boats, people with substance misuse, and families stationed at the local barracks. Staff told us that these patients were supported to register as either permanent or temporary patients. The practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us the patient was usually accompanied by a family member or friend who would translate for them. Staff told us they could use a telephone translation service if required. We did not see any leaflets in different languages for patients, although information could be translated via the website. There were three permanent female GPs at the practice, who were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

The practice provided equality and diversity training through e-learning. Training records indicated that a small number of staff had completed this training.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building with most services for patients on the ground floor. There was a lift to the first floor. There was a hearing loop system available for patients with a hearing impairment. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice leaflet and website outlined how patients could book appointments and organise repeat prescriptions online. This included how to arrange urgent and pre-bookable appointments and home visits. Patients could also make appointments by telephone or in person. 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, they were advised of the telephone number for the out of hours service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice opened from 8.30am to 6pm Monday to Friday. The practice operated a triage system, whereby all requests for same day appointments were reviewed by the duty GP. The duty GP contacted the patient and assessed whether they needed a same day appointment (GP or practice nurse), pre bookable appointment or telephone advice. Surgery times were staggered, either starting at 8.30am or 10am, so appointments were available throughout the day, except between 1pm and 2pm. Some home visits were carried out before morning surgery, enabling earlier admission to hospital if required. The practice recognised the extra workload on Monday mornings or after a Bank Holiday and provided two duty GPs at these times.

Longer appointments were also available for people who needed them and those with long-term conditions. Named GPs were allocated to care for patients in care homes. Home visits were made to three local care homes on a specific day each week by the named GP and to those patients who needed one. GPs visited patients with a learning disability who lived in care homes as and when requested, as well as reviewing their care every three months.

Appointment waiting times was a standing agenda item at the weekly partners meeting. The practice recognised there were challenges around pre bookable appointments. Patients spoken with told us they may wait up to four weeks for a pre bookable appointment with a specific GP. However, they told us there were no issues with same day appointments. Appointments were also highlighted in the patient survey and included in the action plan.

The practice offered a range of services for patients with mental health needs. The lead GP for mental health holds a two weekly clinic for patients with severe mental health needs and learning disabilities, as well as visiting patients at home. These patients were offered longer appointments and the majority had individual care plans in place. Good working relationships were in place with other services for people with mental health needs, for example the Primary Care Liaison Service. GPs were able to make appointments for patients directly with the service, and patients were usually seen within one or two weeks. The practice also worked closely with the Community Substance Misuse Team, and provided shared care for patients requiring methadone prescriptions. The practice made referrals to Child and Adolescent Mental Health Services (CAMHs) to provide support for children experiencing poor mental health.

The practice manager told us the practice was not always able to offer routine appointments outside of school hours for children. However, children were always offered a same day appointment if required. Systems were in place to monitor mothers to be, from confirmation of pregnancy through to the six week post natal check. Family planning services, including emergency contraception were available at the practice. Patients had access to a weekly sexual health clinic held in the same building, which also offered a free condom distribution scheme.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. However, the complaints policy needed updating to reflect the staff changes. There was a designated responsible person who handled all complaints in the practice. Patients were made aware of how to complain through the complaints leaflet and information on the website. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

We saw that the practice recorded complaints and had received 12 during 2014. We followed the pathway for two complaints received by the practice. We found that there was an open and transparent approach towards complaints. We saw that these had been handled satisfactorily and discussed at the significant event meetings and reception staff meetings. However, we found that the response letter to the complainant did not make reference to the Health Service Ombudsman.

We saw that the practice used information from complaints to improve the service and develop staff. We saw that one complaint related to the attitude and explanation given by a member of staff. As a consequence, priority had been given to staff completing the online customer care training. Training records supported that the majority of staff had completed this training.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality, safe and effective medical care and promote good outcomes for people. The practice mission statement was 'to provide a high quality of patient care in a cost effective manner, delivered by a trained and committed team'. However, the practice did not have a business plan in place to support delivery of the mission statement.

The practice was proactive in its approach to develop the services they provided. The practice manager told us they had identified that additional phlebotomy (taking blood) appointments were required. As a consequence additional staff had been recruited. The practice had also identified that the role of the health care assistants could be expanded and were providing additional training for these staff.

Governance arrangements

The practice had invested in a governance system called IQ CQC. The system contained policies which could be downloaded and adapted to meet the practice's needs. All staff had access to policies, procedures and clinical guidelines either through paper copies which were stored in files or through information available on the practice's intranet. Staff were aware of the access arrangements on the computer system. We saw that policies had not always been adapted to the needs of the practice, for example the chaperone policy. In addition the practice did not have a system in place for reviewing and updating policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and each of the GPs had a lead role, for example safeguarding, mental health and child health. We spoke with nine 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.

Communication between and amongst the different groups of staff was both formal and informal. The practice held a range of meetings, which included partner meetings, clinical meetings and significant event meetings. Full staff meetings, nurses, reception and administration staff meetings were also held. However, not all meetings were minuted, for example nurses meetings and full staff meetings.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 99.1 out of a possible 100 points. This was above the average score achieved nationally and within the local Clinical Commissioning Group.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example: infection control, home visits and monitoring of blood results for patients prescribed certain medicines

The practice had robust arrangements for identifying, recording and managing risks. Risk assessments had been completed, for example: fire safety, legionella virus and portable equipment.

Leadership, openness and transparency

The registered manager and practice manager told us about their plans to restructure the senior management team following recent changes in personnel. The aim was that each member of the team had clear responsibility for the delivery of specific functions. As a consequence a new organisational chart had been developed, and roles and responsibilities redefined. An action plan had been developed and was due to be implemented to support these changes. Staff spoken with told they now felt more involved in the running of the practice. They said they understood the reasons for changes that had been made, for example changes in staff roles and responsibilities.

We saw that named members of staff had lead roles. Each GP was the lead for an area of clinical care. For example: diabetes, dermatology and coronary heart disease. One of the practice nurses was the lead for infection and responsible for carrying out the infection control audits. Another member of the nursing team was responsible for managing the ordering of medicines. We spoke with staff

Are services well-led?

Good

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

from different teams 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.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints. The 2013 / 2014 patient survey focused on difficulty in making an appointment and appointment availability. The practice had worked with the Patient Participation Group (PPG) to design the survey and address the issues highlighted. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The survey indicated some improvements had been made. In particular access via the telephone, seeing a GP within two working days, seeing a nurse and more positive comments made by patients. An action plan had been developed and implemented.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Participation Group (PPG). The practice had an active Patient Participation Group (PPG). The PPG recognised that it was not representative of the ethnicity or gender of the population of the practice. The PPG supported the annual patient survey and held meetings on a regular basis. However the minutes of the meetings were not available on the website or on the notice board in the waiting room for all patients to see. The chair person for the PPG commented that the relationship between the PPG and the practice had improved following the restructure of the management team.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. Staff told us that they received an annual appraisal, which identified any training and development needs for the following 12 months. Staff told us they were provided with protected learning time through the year. The practice also held weekly educational meetings for all clinical staff.

The practice was a training practice for foundation year doctors and GP Registrars. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. Foundation Year doctors are qualified doctors undertaking speciality placements. We spoke with a GP registrar who told us they felt well supported. They said they had a named mentor, had completed an induction programme and attended twice weekly teaching sessions.

The practice was able to evidence through discussion with the GPs and practice manager and via documentation that there was a clear understanding among staff of safety and of learning from incidents. Concerns, near misses, Significant Events (SE's) and complaints were appropriately logged, investigated and actioned. For example, we saw that the outcome of critical incidents and complaints received had been discussed at the management meeting held on 3 November 2014. However, the minutes of meetings were not shared with non attendees.