West Farm Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of West Farm Surgery on 10 March 2015.

Overall, we rated the practice as good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Staff reported feeling able to voice any concerns or make suggestions for improvement
- Risks to patients were assessed and well managed. The practice learned from incidents and took action to prevent any recurrence.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider needs to make improvements.

The provider should:

- Introduce systems to record minor incidents to enable the practice to pick up on themes and trends.

Summary of findings

- The provider should ensure that there are storage facilities and processes in place for the appropriate storage of samples for collection.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. However, we were told that minor events and incidents were discussed at practice meetings but they were not always logged or minuted.

Prescription were kept locked away and distributed in small numbers to GPs. Staff recorded the batch numbers of those prescriptions. We were told that the consultation rooms were locked after surgery and when staff left the room which ensured the security of prescriptions.

The practice undertook regular infection control audits. Two audits highlighted the fact that samples were stored in the vaccination refrigerators for collection. The practice manager told us that they were in the process of purchasing a refrigerator specifically for storing samples.

There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Care and treatment was being delivered in line with current published best practice. They used the data from the Quality Outcomes Framework (QOF) to assess how the practice was performing. For 2014 the practice achieved an overall total score of 95.9% which was 0.9% below the local CCG average, but 2.4% above the England average

Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audits.

Staff had received training appropriate to their roles. The practice worked with other healthcare professionals to share information.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The results of the National GP Patient Survey (2015) showed patients felt the GPs and nurses involved them in decisions about their care. We saw that 95% of patients who responded said they had confidence and trust in their GP, compared to the national average 92% and 92% said

Summary of findings

their GP was good at treating them with care and concern, compared to the national average 83%. We also saw that 87% of patients who responded said they had confidence and trust in their nurse, compared to the national average of 86% and 82% said their nurse was good at treating them with care and concern, compared to the national average 78%.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

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 and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We saw that lessons were learnt from complaints and shared with staff.

Patients experiencing poor mental health had their needs reviewed. For example, data showed that 93.5% of patients on the dementia register had their needs reviewed within the preceding 12 months. This was 11.2% higher than the local CCG average and 9.7% above the England average.

Are services well-led?

Good

The practice was rated as good for well-led. The practice had a clear vision and strategy which had quality and safety as its top priority. There was also a strategy in place to implement this vision.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management team. 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 they acted upon. There was an active patient participation group (PPG). Staff had received inductions, performance reviews and attended staff meetings and events. We found there was a high level of staff satisfaction.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. For example, the practice had identified 123 patients who needed support. They each had a care plan and were regularly reviewed by a GP. These patients were provided with a direct access telephone number so that they can quickly access medical advice from the practice.

Patients over the age of 75 years had a named GP. The practice was responsive to the needs of older people, including offering home visits.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

The practice had systems to ensure care was tailored to patients' individual needs and circumstances. We spoke with GPs and nurses who told us regular patient care reviews, for example for patients with chronic obstructive pulmonary disease (COPD - severe shortness of breath caused by chronic bronchitis, emphysema, or both) or asthmatic conditions, took place.

The practice ensured timely follow-up of patients with long-term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Families, children and young people

Good

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

The practice provided GP led baby clinics in addition to midwife and health visitor clinics. Immediate access for sick children to be assessed by a GP was available when necessary. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, health visitors attended regular multidisciplinary meetings held by the practice to discuss safeguarding issues.

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed.

Summary of findings

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, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, they offered an online service where patients could access their medical records. The practice provided a telephone consultation service.

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.

Systems were in place to identify patients, families and children who were at risk or vulnerable. These patients were offered regular reviews. The practice worked in collaboration with other agencies, for example, health visitors and district nurses, to ensure vulnerable families and children and other patients were safe. Multidisciplinary meetings were also held regularly to monitor the care provided.

The practice worked with patients being treated for addictions and provided personalised support.

The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities to ensure they were safeguarded.

People experiencing poor mental health (including people with dementia)

Good

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

Patients experiencing poor mental health had received an annual physical health check. The practice worked closely with multidisciplinary teams in the case management of people experiencing poor mental health. For patients with dementia their care had been reviewed in a face-to-face appointment in the preceding 12 months.

The practice worked with patients experiencing poor mental health and provided personalised support.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection. They told us the staff who worked there were caring and understanding, and there were no problems getting appointments. They also told us they found the premises to be clean and tidy.

We reviewed seven CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey published in January 2015 showed the majority of patients who responded were satisfied with the services the practice offered. The results were:

- 88% of patients who responded said they would recommend their GP surgery, compared to a national average of 78%;
- 76% of patients who responded said they were 'fairly satisfied' or 'satisfied' with the opening hours, the same as the national average of 76%;
- 94% of patients who responded said that it was 'very easy' or 'easy' to get through on the telephone, compared to the national average of 72%;
- 78% of patients who responded said that their experience of making an appointment was 'fairly good' or 'very good', compared to the national average of 74%;
- 90% of patients who responded said their practice was 'fairly good' or 'very good', compared to the national average of 85%.

These results were based on 110 surveys that were returned from a total of 305 sent out; a response rate of 36%.

Areas for improvement

Action the service SHOULD take to improve

- Introduce systems to record minor incidents to enable the practice to pick up on themes and trends.
- The provider should ensure that there are storage facilities and processes in place for the appropriate storage of samples for collection.

West Farm Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist advisor and specialist advisor in practice management.

Background to West Farm Surgery

West Farm Surgery provides services to 5,692 patients, from 31 West Farm Avenue, Longbenton,

Newcastle Upon Tyne, NE12 8LS. The practice provides their services under a NHS General Medical Services (GMS) contract to patients in their catchment area.

The practice is located in a two storey building, all patient facilities are situated on the ground floor. It also offers a disabled WC, wheelchair and step-free access. There is unrestricted street parking close to the practice.

The practice has four partners and one salaried GPs (four female and one male GP), two practice nurses, two health care assistants, a practice manager, and nine reception and administration support staff.

The opening hours for the practice are 8.20am to 6.00pm Monday to Friday. The practice is closed on Fridays between 1.00pm and 2.00pm. For the periods 8.00am to 8.20am and 6.00pm to 6.30 calls will be redirected by the 111 service to the practice's on call doctor.

The service for patients requiring urgent medical attention out of hours is provided through the 111 service and Northern Doctors Medical Services Limited between 6.30pm and 8.00am Monday to Friday.

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.

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 the time.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before visiting we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG). This information did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 10 March 2015. We spoke with six patients, which included two membesr of the patient participation group (PPG). We also spoke with, two GP partners, two GP registrars, two nurses, two health care assistant, the practice manager and two of the administration team. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed seven CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that a significant event led to the introduction of a new protocol for dealing with patients suspected of suffering with inflammation of the walls of a vein. The practice also invited a consultant in haematology to provide further training on this and deep vein thrombosis – the obstruction of a vein by a blood clot. We found that event had been dealt with appropriately to avoid any recurrences and had been discussed with relevant staff. The outcome of the review of the incident was also shared with the out of hours services.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. The practice had a significant event audit (SEA) policy and procedures that staff followed. SEAs enable the practice to learn from patient safety incidents and 'near misses', and to highlight and learn from both strengths and weaknesses in the care they provide. We saw records for 2014 which listed four significant events and reviewed one in detail. However, staff told us that minor events and incidents were discussed at practice meetings but they were not always logged or minuted. This demonstrated that the practice did not routinely record all events and ensure that all learning was shared with relevant staff. The practice also maintained log of safety incidents which helped in identifying any emerging patterns. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the longer term.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards were complimentary about the service they had received and raised no concerns about their safety.

Learning and improvement from safety incidents

The practice was open and transparent when there were 'near misses' or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. The practice manager told us that they used a template to record incidents which was available to all staff on the practice intranet except where the event needed to be kept confidential. We saw records which confirmed this.

In addition to their significant event records the practice used the Safeguarding Incident and Risk Management System (SIRMS). This is an on-line incident reporting system which enables information about incidents to be shared with local CCG member practices. Staff told us that incidents were reviewed at regular practice meetings and changes were made as necessary. We saw evidence, for example, notes of an administration team weekly meeting in February 2015 confirmed this.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources. Staff told us that all safety alerts received by the practice were recorded in a master log which recorded the date of receipt, when the alert was forwarded and actions required and when action had been completed. The alerts were assigned to the relevant group (GPs or nurses etc.) to action. We saw the computer records which confirmed this.

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. We also saw the practice provided guidance on safeguarding for staff which included how to identify, report and deal with suspected abuse. The practice displayed a contact list of other agencies that may need to be informed when concerns arise such as the local police and Social Services.

The practice had a safeguarding lead for both children and adults with responsibilities for overseeing safeguarding within the practice. We saw records which showed that all GPs had received Level 3 training in respect of safeguarding children. The administration team had received Level 1 training as an eLearning course. In addition staff told us that some of the administration team also attended in-house safeguarding training. We saw training records that confirmed all staff had received training in

safeguarding adults. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

The practice had a chaperone policy. There were notices on display in the waiting area to inform patients of the availability of chaperones. Staff told us that the chaperones were trained. The staff we spoke with were clear about the requirements of their roles as chaperones. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) All the chaperones had been checked by the Disclosure and Barring Service (DBS). The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked vaccines stored in the medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the vaccine refrigerators were monitored daily by the nurses. Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). PGDs and PSDs are specific guidance on the administration of medicines authorising nurses and health care assistants to administer them.

The practice had a process to securely store prescriptions. Prescriptions were kept locked away and distributed in small numbers to GPs. Staff recorded the batch numbers of those prescriptions. We were told that the consultation rooms were locked after surgery and when staff left the room which ensured the security of prescriptions. However, we found one consulting room was unlocked and no one was in the room. We discuss this with the practice manager who apologised and said they would remind staff to lock the doors when the rooms when unoccupied.

We saw that the practice had a safe system for dealing with repeat prescriptions and other medication requests.

The practice was supported by a pharmacist. Their role included working closely with GPs to undertake medication reviews with patients by telephone or face to face meetings. A medicines review includes an examination of a patient's medicines, reaching an agreement with the patient about treatment, optimising the impact of medicines and minimising the number of medication related problems.

Cleanliness and infection control

The practice was clean, tidy and well maintained. The patients we spoke with about the cleanliness of the practice told us that it was always clean and tidy.

The practice had a lead for infection control and an infection control policy. All of the staff we spoke with about infection control said they knew how to access the practice's procedures for infection control and had received infection control training. Infection control audits took place quarterly. We saw the November 2014 and January 2015 audits. They highlighted the fact that samples were stored in the vaccination refrigerators for collection. We discussed this with the practice manager who told us that they were in the process of purchasing a cool box specifically for storing samples.

The risk of the spread of infection 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. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. We saw training records that showed all staff had received infection control training.

The practice employed a cleaning contractor. The practice had cleaning schedules for example weekly schedules to indicate which areas required cleaning. In addition the health care assistance undertook weekly checks of the premises which included the cleanliness of rooms.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

We saw that a legionella (legionella is a bacterium that can grow in contaminated water and can be fatal) risk assessment had taken place. We saw evidence that the practice undertook monthly water temperature checks which showed that the temperatures were with the recommended ranges.

Good

Are services safe?

Equipment

The practice had processes in place to make sure that equipment was regularly checked to ensure that it was safe and effective to meet patients' needs. The fire extinguishers were checked in September 2014. The practice had contracts in place for medical equipment to be check or calibrated. We saw that the scales and blood pressure machines were calibrated in April 2014. We saw that a portable appliance test (PAT) had been undertaken recently. (Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.)

Staffing and recruitment

We saw that the practice had a recruitment policy. The practice manager told us they took up references. Staff we spoke with confirmed this. They also obtained photographic proof of identity and satisfactory documentary evidence of any relevant qualifications in accordance with regulations. We looked at recruitment records for three members of staff which confirmed this. The practice undertook an induction process for all new staff. We spoke with a new member of staff who confirmed that they had undertaken a period of induction.

All clinical staff that were in contact with patients had been subject to DBS checks. This demonstrated that the practice had taken reasonable steps to ensure that the staff they employed were suitable to work with vulnerable patients.

The practice manager told us that they employed sufficient numbers of suitably qualified, skilled and experienced staff. The teams multi-tasked. This flexibility in their roles helped the practice deal with routine absences such as sickness. The practice if necessary also increased the hours of part-time staff to cover absences. We saw that the practice had recently held a partnership strategy meeting to discuss demand and capacity. Staff told us that colleagues were very supportive and they were a really good team. The practice had a procedure for managing staff absences.

Monitoring safety and responding to risk

The practice had a well-established system in place to manage and monitor health and safety. They had a health and safety policy, which reminded staff of their individual responsibility for the health and safety of themselves and other people who may be affected by the practice's activities. Staff received health and safety training at induction and regular refresher training.

Staff told us that the fire alarms were tested every Friday and fire drills which included evacuating the practice were undertaken every four months.

Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, a fire or flood. The practice manager told us that copies of the plan were kept off-site so this could be accessed if practice staff were unable to gain entry to the practice. The plans included essential contact numbers such as electricity suppliers and the water authority.

The practice had resuscitation equipment and medication available for emergencies. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All of the staff we spoke with told us they had either attended CPR (resuscitation) training or refresher training had been scheduled. We looked at records which confirmed this. Clear guidance was available for staff on how to deal with a medical emergency, including when they needed to seek help from emergency services such as paramedics or ambulance staff. This ensured staff had sufficient support and knew what to do in emergency situations.

The practice provided a bypass telephone number to patients most at risk of deteriorating health to enable them to contact the practice quickly when necessary. This phone number was also given to other care providers and services, such as care homes and hospitals.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was considered in line with recognised best practice standards and guidelines.

GPs and nurses demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was an emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and from local health commissioners North Tyneside Clinical Commissioning Group (CCG).

We saw that the practice used the Information from the Quality and Outcomes Framework (QOF) to monitor their patients. For 2014 the practice achieved an overall total score of 95.9% which was 0.9% below the local CCG average, but 2.4% above the England average. (The 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, e.g. diabetes and implementing preventative measures. The results are published annually).

The practiced had processes in place to ensure current guidance was being followed. They used the data from the QOF to assess how they were performing following the current guidance. The practice was aware of their achievements in comparison to other local practices and nationally monitoring their QOF performance on a daily basis. The QOF data showed that the practice achieved scores broadly in line with the local CCG and England averages across the various clinical areas. For example, the overall individual score for palliative care was 100% which was the same as the local CCG average and 3.3% above the England average.

The practice coded patient records using specific READ Codes. These are codes which provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems. This enabled them to easily identify patients with long-term conditions and those with complex needs. We found from our discussions with the GPs and the nurses that staff completed, in accordance 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. There were regular clinics where patients were booked in for an initial review of their condition; they were then scheduled for recall appointments. This ensured patients had routine tests, such as blood or spirometry tests to monitor their condition (A spirometer measures the volume and speed of air that can be exhaled and is a method of assessing lung function).

We saw evidence that the practice were appropriately reviewing the healthcare needs of people with long term conditions. The practice achievement was variable but broadly in line with the national averages. For example, patients with asthma the QOF data showed that 72% had an asthma review within the previous 12 months, which was 3.5% below the national average. For patients with hypertension (high blood pressure) aged 16 or over, 87.9% had an annual assessment of physical activity in the preceding 12 months, which was 9.3% above the national average.

Staff told us that all patients over the age of 75 had a named GP who was responsible for their care. Patients could request a different GP if that was their preference. This helped to ensure continuity of care.

The practice kept a register of patients with learning disabilities which enabled them to monitor their care effectively. There were 49 patients on the register.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw records of nine audits that had been undertaken in the last 12 Months. We looked in detail at two audits. We saw that the audits were comprehensive and adhered to national guidance and local guidelines. Full audit cycles had been completed and changes had been made where necessary. For example the practice found there were inconsistencies in their monitoring of patients who were prescribed a specific antibiotic. As a consequence a number of patients did not have their blood tests monitored according to the guidelines. The results of a second audit showed that the new protocol which the practice had introduced had been followed. It also showed that there had been an improvement in the number of patients who were being monitored in accordance with the guidelines. The second audit we looked at was a comprehensive review of their clinicians' adherence to the

Good

Are services effective?

(for example, treatment is effective)

national and local prescribing guidelines in respect of prescribing a specific drug. We saw that a full audit cycle had been completed which showed improvements in prescribing practice and adherence to the current guidelines.

The practice used the information from QOF to monitor the practice's progress against their QOF targets to ensure that patients were invited for routine regular monitoring tests such as blood pressure checks.

We saw evidence that patients with complex needs had their care planned. For example QOF data showed that 84.6% of patients with mental health issues had a comprehensive care plan documented in the record, in the preceding 12 months; this was slightly below the average for the local CCG by 3.2% and 1.3% below the England average. The practice also achieved 95.8% in the 'Cancer' category, which was 0.6% above the local CCG average and 4.3% above the England average.

Effective staffing

Practice staffing included administrative, clinical and managerial staff. We saw that the practice had undertaken a training needs assessment in February 2015 which highlighted to the practice any training requirements. We reviewed staff training records and saw that the practice had a method of recordings training undertaken and when the training needed updating. Clinical staff maintained their individual continuing professional development (CPD) records. Good medical practice requires doctors and nurses to keep their knowledge and skills up to date throughout their working life and to maintain and improve their performance. CPD is a key way for them to meet their professional standards.

We saw from the staff training records that staff had attended courses which included safeguarding for children and vulnerable adults. Staff were up-to-date with mandatory courses such as basic life support. Staff undertook 'Time in' and 'Time out' training courses which gave the staff an opportunity to undertake undisturbed formal and informal training.

All GPs were up to date with their yearly continuing professional development requirements and all 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 the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England).

All staff had received an annual appraisal. We saw records that confirmed this. During the appraisals, training needs were identified and personal development plans put into place. The practice had an 'open door' policy whereby all staff were encouraged to freely raise any issues or concerns in meetings or privately with the practice manager and GPs. Staff we spoke with confirmed this and told us they would have no problems in raising any issues and also said they felt well supported by the practice. Nursing staff told us that they worked well as a team and were mutually supportive.

We looked at the training records for the practice and saw that they offered staff training that covered safeguarding, fire safety and Cardiopulmonary resuscitation (CPR), among other courses appropriate to their work.

The patients we spoke with were complimentary about the staff. There were positive comments, about staff in the eight CQC comment cards we reviewed.

Working with colleagues and other services

The practice worked closely with other health and social care providers to co-ordinate care and meet their patients' needs. The district nursing team was based at the practice. We spoke with a district nurse who told us that they were always invited to practice meetings and there was effective communication on a daily basis between the district nurses and the practice. They also told us that they had undertaken joint visits with a GP which helped coordinate effective care for patients in their own homes. The district nurse gave an example of how the GPs and the district nurses worked well and agreed a plan to manage the care for a patient who wished to access the services in a particular way. The patient was very concerned that they may be recognised if they attended clinics that were offered to patients with her condition. Alternative arrangements were made which enabled them to access the care and support they needed in a more confidential manner.

Multidisciplinary meetings which included practice nurses, GPs, district nurses, health visitors and other health care professionals were held regularly.

Good

Are services effective?

(for example, treatment is effective)

Correspondence from external health care and service providers, such as letters from hospital including discharge summaries, blood tests, information from out-of-hours providers and the 111 service, were received both electronically and by post and distributed to relevant staff to action.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. These records generated alerts which included prompts to staff that a patient needed medical reviews such as blood tests and if a patient was carer.

Staff told us that they shared patient information with the out of hour's service which helped ensure that their patients received appropriate care. For example, the practice had care plans in place for patients at risk of admission to hospital which were available to the out of hours service and emergency services. Copies of the care plans were kept electronically in the practice and hard copies were available at the patients' home.

Regular meetings were held throughout the practice. These included staff, clinical and multidisciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed with appropriate staff and other health care professionals to enable continuity of care.

Consent to care and treatment

Staff we spoke with were able to give examples of how they obtained implied, verbal and written consent.

We saw training records which showed that all clinical staff had received training in the Mental Capacity Act (MCA) 2005 Act in March 2014. We found that staff were aware of the MCA and their responsibility in respect of consent prior to giving care and treatment. They described the procedures they would follow where patients lacked capacity to make an informed decision about their treatment. The practice gave us an example of a dementia patient where they had concerns about how an appointment had been made by a relative to have their mother's capacity assessed.

The clinicians we spoke with showed they were knowledgeable about how and when to carry out 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.

Health promotion and prevention

A range of health promotion information was available to patients in the reception and waiting area of the practices. This included information about lifestyle management such as smoking cessation, alcohol awareness and advice on exercising.

The practice proactively identified patients who needed ongoing support. In particular, they identified carers and placed a flag on their records so that clinicians were made aware of this before these patients attended appointments. The practice offered annual reviews for patients with long term conditions or more frequently when needed.

The practice identified patients who would benefit from treatment and regular monitoring, for example, they offered flu vaccinations and immunisations for children in line with current national guidance. Data showed that 100% of children received the second dose of the MMR vaccination, compared to the local CCG average of 98.3%.

The practice told us that they were proactive and opportunistic when offering NHS health checks to patients. The practice offered various health checks which included health checks for patients from 40 to 70 years old.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with six patients during our inspection. They were complimentary about the services they received. Comments left by patients on the seven CQC comment cards we received also reflected this.

We looked at data from the National GP Patient Survey, published in January 2015. The results showed that patients who responded were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 90% of patients who responded to the survey said they thought their overall experience was good, compared to the national average 85%. For the helpfulness of reception staff the practice achieved 95%, compared to the national average 87%. We saw that 95% of patients who responded said they had confidence and trust in their GP, compared to the national average 92% and 92% said their GP was good at treating them with care and concern, compared to the national average 83%. We also saw that 87% of patients who responded said they had confidence and trust in their nurse, compared to the national average of 86% and 82% said their nurse was good at treating them with care and concern, compared to the national average 78%.

Staff we spoke with told us how they would protect patient's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

We saw the reception staff dealt with patients pleasantly and warmly. They were aware of the need for confidentiality. They ensured conversations were conducted in a confidential manner. For example, there was a sign on the reception floor marking a privacy boundary where patients waited to be called to the reception desk. Reception staff spoke quietly so their conversations could not be overhead. In addition patients were offered a private room to speak to reception staff in confidence if they wished.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They told us that the clinical staff took their time with them and always involved them in decisions. The results of the National GP Patient Survey published in January 2015 showed patients felt the GPs and nurses involved them in decisions about their care. Of the patients who responded 82% rated the GPs good at involving them in decisions, compared to the national average 75%. For nurses this was 75% compared to the national average 66%. In addition 94% of patients who responded rated GPs good at explaining the need for any test or treatments, compared to the national average 82%. For nurses this was 79% compared to the national average 77%. This demonstrated that most patients who responded were satisfied with the way they were treated.

We saw that access to interpreting services was available to patients, should they require it.

Patient/carer support to cope emotionally with care and treatment

Staff told us that in addition to pre-bookable appointments the practice offered urgent appointments on the same day and no one was refused an urgent appointment. In addition, the nurses would return patients telephone calls to discuss the issues at a time that was convenient to the patient. These services gave patients assurance that their needs would be met on the day they contacted the practice. The practice also undertook home visits for those patients not well enough to attend the practice.

The practice offered support to patients receiving end of life care at home. Each patient receiving palliative care had a named GP and the practice had arrangements in place to ensure that another GP was available should the named GP be unavailable. These patients had care plans which included a section to record their wishes in the event of cardiac or respiratory arrest.

Staff told us that bereaved relatives and carers would be contacted by the practice to offer them support shortly after the bereavement and then 12 weeks later. The practice had access to a local befriending service which they could signpost patients to if they required further support.

Good

Are services caring?

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and various support groups and services.

The practice worked with patients experiencing poor mental health and provided personalised support. For example, the practice had strong links with the community matron. Where the practice had identified some patients experiencing poor mental health who were not engaging with them the practice sought help from the community matron to ensure these patients received care.

The practice also held regular multidisciplinary team meetings where they planned care for patients who would benefit from coordinated support from other health care providers in conjunction with the care provided by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff told us that patients suffering from some long term conditions were given longer appointment times if necessary. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey published in January 2015 confirmed this with 93% of patients who responded stating that the doctors gave them enough time and 84% had sufficient time with the nurses. These results were above the national averages (85% and 80% respectively).

The practice undertook care planning for patients diagnosed with diabetes which included proactively inviting these patients for a check-up every six months. From the care plans we saw we could see that the patients were involved in planning their own care. The plans included details of blood tests, blood pressure, weight, smoking, and dates for eye and foot tests. The plans also included explanations of why certain parameters were set and target levels to achieve. The plan included a section on what the patient wished to work on and what was important to them. Action plans were agreed with the clinician.

The practice used electronic notes and alerts which were attached to medical records to advise staff that patients had additional needs such as, for example, a learning disability or that they were a carer.

The practice offered personalised care to meet the needs of the older patients in its population. For example, the practice had identified 123 patients who needed support. They each had a care plan and were regularly reviewed by a GP. These patients were provided with a direct access telephone number so that they could quickly access medical advice from the practice.

All patients over the age of 75 years and those patients on the palliative care register had a named GP.

The practice worked with patients being treated for addictions and provided personalised support.

There was information available to patients in the waiting room and reception area about support groups, various clinics such as the flu clinics, and health and wellbeing advice.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. Patients experiencing poor mental health had their needs reviewed. For example, 93.5% of patients on the dementia register had their needs reviewed within the preceding 12 months. This was 11.2% higher than the local CCG average and 9.7% higher than the national average.

We saw that the practice took a sensitive approach to registering homeless patients. For example, they took into account that these patients were not always able to provide photographic forms of identification or the full range of documentation normally required for registration.

Staff told us that the practice offered extended appointments for patients who needed them.

There was unrestricted street parking near to the practice. The practice buildings had step free access for patients with mobility difficulties. The practice also had a hearing loop system for patients with hearing difficulties. The consulting and treatment rooms were accessible for all patients. There were disabled toilet facilities available at the practice.

The practice had arrangements in place to access interpretation services for patients whose first language was not English. Staff also showed us that they used a set of picture cards to help them communicate with patients with communication difficulties which help these patients to become more effectively involved in their care and treatment.

Access to the service

The opening hours for the practice were 8.20am to 6.00pm Monday to Friday. The practice was closed on Fridays between 1.00pm and 2.00pm. For the periods 8.00am to 8.20am and 6.00pm to 6.30 calls will be redirected by the 111 service to the practice's on call doctor.

Appointments were available Monday to Friday. GP appointments were available from 8.30am to 5.50pm and

Good

Are services responsive to people's needs?

(for example, to feedback?)

nurse appointments from 8.30am to 5.45pm. Ante Natal clinics were held Tuesdays between 1.30pm and 4.30pm, and baby clinic were held on Wednesdays between 1.30pm to 2.30pm.

Staff told us that patients needing an urgent appointment would get an appointment with any GP that day and children were always seen by the end of the morning or afternoon sessions. Immediate access for sick children to be assessed by a GP was available when necessary. Feedback from patients we spoke with, and those who completed CQC comment cards, did not raise any concerns about getting an appointment with a clinician on the day if their need was urgent.

Patients were able to book appointments either by calling into the practice, on the telephone or online. Home visits were available and telephone consultations for patients who needed them.

Patients we spoke with commented on the appointments system. They said they were satisfied with the appointment systems operated by the practice. They commented that it was easy to get an appointment. This was reflected in the results of the most recent National GP Patient Survey (2015). This showed 78% of respondents described their experience of making an appointment as 'very good' or 'fairly good', in comparison to the national average 74% and 98% said that the last appointment they got was 'convenient for them', in comparison to the national average 92%.

The practice had an up-to-date practice leaflet which provided information about the services available, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

Listening and learning from concerns and complaints

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

There was information displayed in the waiting room and within the practice complaints leaflet, informing patients of the practice complaints process. The practice leaflet explained that the practice manager would be happy to deal with any concerns patients had about the services they provided.

None of the six patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the seven CQC comment cards completed by patients indicated they had felt the need to make a complaint.

We saw that the practice had recorded their complaints in an annual register. We saw that they had received five complaints between April 2014 and the date of our inspection. A summary of the complaint and details of the steps taken to address the complainant were recorded. Any learning from the complaints was recorded and shared with staff at staff meetings. For example, a repeat prescription was not ready for collection on time because the practice's prescribing policy had not been followed. The practice apologised to the patient about the error and reminded staff of the need to follow the policy.

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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 mission statement which was, 'To deliver high quality care to improve and maintain the health of our patients in a professional and compassionate manner in a modern, safe and friendly setting.' The practice held annual strategy meetings to review past performance and set objectives for the next 12 months. We saw minutes of a meeting held in May 2014 which confirmed this. The staff we spoke with all knew and understood the vision and values and what their responsibilities were in relation to these.

The practice manager told us that the practice had an open culture where staff were encouraged to seek advice and discuss issues with colleagues and GPs when the need arose. Staff we spoke with confirmed this and told us that the practice was very supportive and they had no concerns about raising any matters with colleagues, GPs or the practice manager.

Governance arrangements

We saw that the practice had developed a clear leadership structure showing lines of accountability for all aspects of patient care and treatment. This included details of nominated individuals who were responsible for various clinical and non-clinical areas. For example the assistant practice manager was the lead for monitoring the performance of the practice on key indicators. We saw that they used the reporting analysis and intelligence delivering results (RAIDR) system available from the CCG. They used this system amongst other processes to monitor their patient data to identify any variation from what would be expected and highlight any outlying performance. In addition they used this data to identify patients who had been frequent attenders at hospital. The practice set up a process to try and reduce the number of avoidable attendances to hospital. They analysed the reasons patients had attended A&E and where other services were more appropriate they informed patients of this. Staff told us that data from the CCG demonstrated that the level of avoidable attendances had reduced following the introduction of that process. The assistant practice manager regularly kept the practice informed of their progress against the key indicators.

The practice had a number of policies and procedures in place which governed their day-to-day activities. Staff were able to access these electronically. Staff told us that they worked in accordance with their policies and procedures, for example, they told us they followed patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. The policies and procedures that were in place, and feedback from staff, showed us that effective governance structures were in place.

Staff told us that they interacted with their colleagues throughout the day, supporting each other to provide their services to patients. We saw that the practice held various regular team meetings such as weekly team meetings, monthly clinical meetings with GPs, nurses and health care assistants, and monthly multidisciplinary meetings which included GPs, health visitors, palliative care nurses, community matron, and district nurses.

Leadership, openness and transparency

The practice had a clear corporate structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. Staff undertook lead roles in such areas as infection control and monitoring QOF data and practice performance. The management team had a good understanding of, and were sensitive to, the issues which affected patients and staff.

Staff told us they worked in a supportive team and there was an open culture in the practice and were able to freely discuss any topics. The also felt that they could report any incidents or concerns they might have. This environment helped to promote honesty and transparency at all levels within the practice.

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

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions in their day-to-day activities. Staff we spoke with told us these meetings provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and members of the management team. Staff also told us that the practice was open to suggestions and acted upon them. For example we saw from the notes of a staff meeting in September 2014 that

Are services well-led?

Good

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

staff suggested changes to the way they handled telephone calls to streamline the process. Following the suggestion the practice developed and used a flow chart and scripts that helped staff to determine which service would suit the patients' needs, for example, a nurse or GP appointment, or a telephone consultation and made the appointments. We saw the practice also used the various meetings to share information about clinical and administration issues.

We saw from the practice's patient participation group (PPG) annual report 2013/14 that the practice had commissioned a patient survey in 2013. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. There were 155 respondents to the survey. In conjunction with the PPG the practice analysed the responses and formed an action plan and reviewed their progress against the plan. In addition they developed an action plan for 2014/15 which included moving a work station in reception and displaying privacy markers in the reception area. Both modifications helped in addressing concerns raised by patients about confidentiality.

GPs and members of the practice management team attended PPG meetings. We spoke with a member of the PPG. They told us that the PPG's relationship with the practice was collaborative and constructive; they felt listened to and their opinions were valued. They gave us an example of how they worked together to change the street parking restrictions that were in force close to the surgery, when progress had stalled. The PPG wrote to the local council on behalf of the practice asking for the restrictions to be amended to aid patient access to the surgery. The local council removed the restrictions which had enabled patients to park unrestricted on the streets close to the surgery.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. The practice manager and a GP regularly reviewed and agreed the training objectives for staff and the practice.

The practice manager told us that they had a dedicated team who have many years of experience, skills and knowledge. They supported each other and encouraged and mentored colleagues. Staff told us that the practice was supportive of training. They said they had received the training they needed or it had been scheduled, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw training records which confirmed this.

The practice undertook regular training workshops within the practice. For example the practice held monthly training sessions for staff in addition to any mandatory training they were required to undertake. At a recent lunchtime training session a specialist nurse came to the practice and gave a talk on contraception. Staff also attended 'Time Out' workshops run by the local CCG. The workshops they offered included training in areas such as palliative care guidelines, Mental Capacity Act and antibiotic prescribing. Staff told us that they had appraisals which included agreeing future training courses to increase staff skills. We saw staff records which confirmed this.

The practice was a training practice. The practice provided training placements to medical students. In addition they also provided training placements to post graduate medical students (doctors) to undertake supervised specialist training as part of their GP training. This demonstrated that the practice staff shared their skills and experience with colleagues for the benefit of patients.

The practice had an effective approach to incident reporting in that it encouraged reporting and the review of all incidents. Team meetings were held to discuss any significant incidents that had occurred. We saw minutes of a practice meeting dated February 2015 which included details is of a significant event. The practice had completed reviews of significant events and other incidents and shared these with staff and other relevant health care providers.

The practice was a Royal College of General Practitioners research accredited practice. This accreditation enabled the practice to participate, with the support and consent of patients when necessary in research into various medical issues. The practice had undertaken numerous studies in the past and some are ongoing. This demonstrated that the practice was willing to engage with the wider health community in finding ways to improve the care and treatment of patients.