Ball Tree Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Ball Tree Surgery on the 6 January 2015. The practice has an overall rating of good.

Ball Tree Surgery provides primary medical services to people living in Sompting, Lancing and East Worthing. At the time of our inspection there were approximately 8,500 patients registered at the practice with a team of four GP partners. A fifth GP was in the process of registering as a partner with CQC. The practice was also supported by a salaried GP, nurses, healthcare assistants and a team of reception and administrative staff. Ball Tree Surgery is a GP training practice and at the time of the inspection was providing training and support to two registrars.

The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice and staff told us they felt supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

- GPs had their own patient lists and where possible encouraged continuity of care by patients seeing their named GP.
- Patient feedback about the practice and the care and treatment they received was very positive.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy.
- There was evidence the practice was listening to its patients and responding to any concerns or suggestions in a timely and effective manner.
- The practice had systems to keep patients safe including safeguarding procedures and means of sharing information in relation to patients who were vulnerable.
- There were a range of appointments to suit most patients' needs.
- Patients with palliative care needs were supported using the Gold Standards Framework.

Summary of findings

- The practice had been a training practice for 25 years and there was a culture of continuous development.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- Innovative use of the practice computer system allowed for information to be recorded, stored and shared in a pro-active way which was both beneficial to the practice and its patients

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient'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 was able to demonstrate that appraisals and personal development plans had taken place for all staff. Staff worked with local multidisciplinary teams to provide patient centred care. Patients had a named GP which allowed for continuity of care.

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. During the inspection we witnessed caring and compassionate interactions between staff and patients. Patients had access to local groups for additional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. The practice had

Summary of findings

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. There was evidence of shared learning from complaints with staff and patients. The practice had arrangements in place to support patients with disabilities. The layout of the building enabled patients with mobility problems to gain access without assistance. Home visits and telephone consultations were also available.

Are services well-led?

Good

The practice was 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 priority for the practice was provision of a high quality, safe service for its patients. The leadership, management and governance of the practice ensured the delivery of high quality, patient centred care. The service was proactive and effectively anticipated and responded to change. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff were encouraged to make suggestions for improvement and we saw evidence suggestions were acted on. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.Staff we spoke with felt valued and were supported through regular meetings with managers, team meetings and appraisals.

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. Patients had a named GP which allowed for continuity of care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. The practice had a housebound register and those patients had annual reviews. The practice used computerised risk stratification tools to identify patients at risk including those at risk of hospital admissions and worked closely with the proactive care team which included district nurses, community matron, physiotherapists, occupations therapists and pharmacists to plan care accordingly. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Clinics available included diabetic reviews and blood tests. The practice also monitored blood pressure.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All patients had a named GP and a structured annual review to check that their health and medication needs were being met. Where patients had more than one long term condition all of their needs were reviewed in one longer appointment to avoid multiple visits.The practice nurses were trained and experienced to support patients with managing their conditions and preventing deterioration in their health. For those people with the most complex needs, the named GP worked with relevant local health and care professionals to deliver a multidisciplinary package of care. Patients with palliative care needs were supported using the Gold Standards Framework.Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

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Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered contraceptive implants and coil fitting. Appointments were available outside of school hours and the premises were suitable for children and babies. Younger patients needing support and counselling were referred for early intervention support. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be seen on the day.

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. Patients were able to request a GP to telephone them instead of attending the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered a travel clinic for advice and vaccinations, which included yellow fever. Patients could be referred to the 'wellbeing' service, 'why weight' and the local alcohol support service to support patients with lifestyle modifications. The practice ran day and evening smoking cessation clinics and offered NHS health checks.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances those with a learning disability. GPs carried out annual health checks for people with a learning disability and where necessary the practice offered longer appointments for vulnerable patients. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff

Summary of findings

knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Patients could be referred to a local service for drug and alcohol abuse and also to the "friends and family support" service for families who may be affected by drug and alcohol. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Carers and those patients who had carers were flagged on the practice computer system and when registering with the practice were signposted to the local carers support team.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients at risk of dementia and those with dementia were flagged on the practice's computer system and had an annual review. The practice had access to the 'living well with dementia' team and the dementia crisis team to provide extra support. Patients with severe mental health needs had care plans where both physical and mental health were assessed as well as annual reviews. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice worked closely with local counsellors, the mental health team and consultants.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views of the practice. We received 14 comment cards which contained positive comments about the practice. We also spoke with six patients on the day of the inspection.

We reviewed the results of the national patient survey from 2013 which contained the views of 134 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 91% of respondents found it easy to get through to the surgery by phone, 88% of respondents described their experience of making an appointment as good and 96% of respondents described their overall experience of this surgery as good. All of these scores were well above the average local Clinical Commissioning Group results.

The practice provided us with a copy of the practice patient survey results from February 2014. The findings indicated over 90% of respondents thought the reception team where helpful or very helpful, 93% said they felt the GP listened to them and 94% said they were treated with dignity and respect.

We spoke with six patients on the day of the inspection and reviewed 14 comment cards completed by patients in the two weeks before the inspection. Both the patients we spoke with and the comments we reviewed were positive. Comments about the practice included that patients felt listened to, cared for and respected. Comments also included that staff were friendly, caring and took the time to listen. Some of the patients had been registered with the practice for a number of years and told us the practice had supported all of their family members.

Ball Tree Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor, a practice manager specialist advisor and a second Care Quality Commission (CQC) Inspector.

Background to Ball Tree Surgery

Ball Tree Surgery offers general medical services to the population of Sompting, Lancing and East Worthing. The practice is involved in the education and training of doctors, practice staff and other healthcare professionals. There are approximately 8,500 registered patients.

The practice is run by four partner GPs. At the time of the inspection a new partner was registering with the Care Quality Commission and we saw evidence of this. The practice was also supported by a salaried GP, practice nurses, healthcare assistants, a team of receptionists, administrative staff, finance and operations manager and a business manager.

The practice runs a number of services for it patients including asthma clinics, diabetes clinics, child immunisation clinics, new patient checks and holiday vaccinations and advice.

Services are provided from:
Western Road
North,
Sompting,
Lancing,
West
Sussex,
BN15 9UX

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice was a GP training practice and supported new registrar doctors in training. At the time of inspection there were two doctors who were receiving general practice training.

The practice population has a higher number of patients between 60 and 85 years of age than the national and local CCG average, with a significant higher proportion of 65-69 year old than the national average. There are a higher number of patients with long term health conditions. The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the

Detailed findings

legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Coastal West Sussex Clinical Commissioning Group (CCG). We carried out an announced visit on 6 January 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patients interaction and talked with six patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 14 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

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 to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. 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 for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at meetings and felt encouraged to do so.

Reported events and issues were recorded onto critical incident reports. We noted that the records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. Evidence of action taken as a result was recorded onto the record. For example, a patient had complained that the practice would not pass on information regarding his wife. We saw that the practice explained their information governance policy to the patient and discussed with staff if this policy was easily accessible for patients to understand. Learning from the complaint indicated the need to review where and how this information was available for patients and to ensure that patients were aware of how they could consent to have their information shared with nominated individuals.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings and if needed during one to one meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. There was a dedicated GP lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (level 3 safeguarding children training). Staff could demonstrate they had received the necessary training to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible in all of the consulting rooms and offices of the practice.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff, including health care assistants, had been trained to be a chaperone. Some receptionists had also undertaken training and understood their responsibilities when acting as chaperones. All staff undertaking these duties had received a criminal records check through the Disclosure and Barring Service. We saw there were posters on display within the waiting room which displayed information for patients.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young

people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

We checked medicines stored in the treatment rooms 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. Staff were able to tell us of an example of where there had been a problem with a medicine refrigerator. Staff told us that due to the temperature exceeding the required levels the stock had been disposed of and a new refrigerator had been installed.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

There were comprehensive medicines management policies in place which included an easy to use flowchart for staff. GPs took ownership of their own patient repeat prescription requests and patient medicines reviews were organised in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. Blank prescription forms were stored securely and were tracked through the practice in accordance with national guidance.

Vaccines were administered by nurses using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives and evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a contract with an external cleaning company which specified the cleaning requirements and frequencies. We observed that this was checked on a regular basis and any issues that had arisen had been brought to the attention of the cleaning company.

The practice had a lead for infection control. They were in the process of undertaking further training and were able to refer to the previous lead for advice if necessary. We noted the lead had established a new tag system which allowed for staff to record on equipment the date it had last been cleaned. This could be checked by any member of staff and ensured that equipment was regularly cleaned. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out infection control audits. The results had been recorded into a spread sheet that was used to monitor any improvements identified and these were discussed at meetings.

An infection control policy and supporting procedures were available for staff to refer to including a policy for needle stick injury. This enabled staff 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 were able to describe how they would use these to comply with the practice's infection control policy.

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

We spoke with the business manager regarding the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). The business manager told us they were aware that an assessment had not been completed recently and this was due to building works being completed at the practice. We were shown evidence of cost estimates for a new water tank to be installed and building plans for new sinks and water storage. We were shown the refurbishment plan which indicated that the works would be completed during stage one which was due to start in January 2015.

Equipment

Good

Are services safe?

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. We saw evidence of calibration of relevant equipment and pat testing had last been completed in August 2014. This included for example weighing scales.

Records showed essential maintenance was carried out on the main systems of the practice. For example, fire alarm systems and the stair lift were serviced in accordance with manufacturers' instructions. Panic alarms were installed in all consulting and treatment rooms in case of emergency. All staff would respond if a call was raised.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment requirements policy that set out the standards it followed when recruiting clinical and non-clinical staff. We noted the practice had a policy for using locums but had not needed to use locum GP for over a year. There was also a comprehensive locum pack which contained relevant practice protocols.

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and could be available for annual leave and sickness absence cover. 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 ensure patients were kept 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example, we saw a recent wheelchair risk assessment and a fire risk assessments which had been completed. The practice also had a lead for health and safety and a health and safety policy.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the business manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all 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. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

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. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, staff shortage and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details for an electrician or plumber.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, the lead for mental capacity had recently provided a learning session for the practice to ensure staff could review and discuss best practice guidelines.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral into secondary care. For example, suspected cancers were referred and seen within two weeks.

The practice used computerised tools to identify patient groups who were on registers. For example, carers, patients with learning disabilities or patients with long term conditions. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management.

The practice has a system for completing clinical audit cycles. Examples of clinical audits included ADHD medicines audit and auditing patients with chronic obstructive pulmonary disease (COPD) to ensure they had care plans and emergency medicines in place. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit for coil procedures. Following the audit, we saw that new guidelines for staff had been recorded as well as information sheets to give to patients and updated consent forms. We saw there was a date that this audit was to be reviewed again to ensure that the audit cycle had been completed.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 96.5% of patients with diabetes had a record of a dietary review by a suitably competent professional in the preceding 12 months. We also noted that 97% of patients with rheumatoid arthritis had a face-to-face annual review in the last 12 months and 92% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question

Good

Are services effective?

(for example, treatment is effective)

and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. The practice worked closely with the local proactive team which included district nurses, community matron, physiotherapists, occupations therapists and pharmacists and created care plans with the patient. Patients were also highlighted on the practice computer system so that their care could be prioritised.

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

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs. 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 NHS England can the GP continue to practice 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 funding for relevant courses. For example, a nurse informed us they had increased their hours and in order to complete patient reviews had undertaken additional training for asthma management. 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.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, travel health and cervical cytology. Those with extended roles, for example seeing patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD) were able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs, a cancer diagnosis or children on the at risk register. These meetings were attended by district nurses, social workers, and palliative care nurses. Staff felt this system worked well.

Information sharing

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

done in a timely manner. Electronic systems were also in place for making referrals. The practice was re-introducing referrals through the Choose and Book system and we saw that recent training had taken place on the system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The business manager showed us a summary record that the practice had created to ensure emergency services had the most relevant information regarding a patient. The business manager had created a template that allowed relevant information to be pulled automatically from the patients electronic records. This template meant that the GPs could be assured that the most up to date patient information was available. It also contained useful information such as patient consent to ensure other services were aware of patients agreeing to have their information shared with nominated individuals.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS to coordinate, document and manage patients' care. All staff were fully trained on the system. Another software product, DocMan, was integrated with EMIS Web and enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of how a patient's best interests were taken into account if they did not have capacity to make decisions or understand information. The practice had drawn up a policy to help staff. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in patient notes. We also saw evidence that the lead for Mental Capacity had given training to staff in July 2014.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting patient consent. The policy provided guidance for staff in relation to the different kinds of consent (implied and expressed), how patients were able to change their mind, where written consent was required and how staff needed to ensure patients were aware of the relevant risks, benefits and complications before they consented to treatment. The policy also highlighted the need for patients to give consent for the sharing of their information when registering with the practice. This ensured that the practice was able to leave messages and share information with specified third parties and access their medical information via an online patient access website. The business manager had created forms within the practices computer system which prompted GPs when renewal of consent was required. The consent could then be used when creating care plans and ensuring that shared information was relevant and up to date. We were shown an example of an ambulance care plan and how these forms had helped to capture consent information that would be of importance to ambulance staff. For example, who the patient would like to be informed in the case of an emergency.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40-75. GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriately timed intervals.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, the practice was reviewing the "patient journey" which included looking at self-help routes and how things could be improved on all

Good

Are services effective?

(for example, treatment is effective)

aspects of patient care. GPs we spoke with told us the practice was planning a patient education health promotion in relation to pre-diabetes and lifestyle modifications. The practice also used the "wellbeing" service to refer patients for support with lifestyle modifications, along with "why weight" and the local alcohol support service.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and invited them to yearly annual reviews. The practice had also identified the smoking status of patients with a physical or mental health condition over the age of 16. We noted that 91% of those patients recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 96% of children aged below 24 months had received their mumps, measles and rubella vaccination. The practice's performance for cervical smear uptake was 81%, which was comparable with other practices nationally. There was a mechanism in place to follow up patients who did not attend screening programmes.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 97% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 94% of practice respondents saying the GP was good at listening to them and 90% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 99% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 98% said the same about the last nurse they saw.

We also reviewed a practice patient survey from 2014 of which the practice. Results showed that over 94% of patients thought they were treated with dignity and respect. When asked the question if they felt the GP listened to them 94% said they agreed.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The reception area and waiting room were separate which allowed for greater privacy for patients. We also noted that telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, asking patients if they wished to discuss private matters away from the reception desk.

Care planning and involvement in decisions about care and treatment

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 86% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above average compared to the Clinical Commissioning Group area. The results from the practice's own satisfaction survey showed that 87% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website also had the functionality to translate the practice information into approximately 90 different languages.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 86% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 91% of patients said the nurses were also good at treating them with care and

Good

Are services caring?

concern. Patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

We saw information was available for carers to ensure they understood the various avenues of support available to them. Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. We were informed that their usual GP would contact the family and when appropriate advice on how to access support services would be given.

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.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the TV information screen contained practice information and the practice produced a patient newsletter, after the patient survey in March 2014 highlighted that patients wanted more information readily available.

GPs had their own patient lists which enabled good continuity of care. Longer appointments were available for patients who needed them and for those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Working age patients were able to book appointments and order repeat prescriptions on line. The practice had late Monday surgeries for GP, nurse and health care assistant appointments. Patients could also book a Saturday morning appointment, which was run on a rota with neighbouring practices.

Patients experiencing poor mental health were supported by the GPs and local mental health teams. Younger patients needing support and counselling were referred for early intervention support. The practice also provided rooms for counsellors from 'time to talk' which patients could be referred to. A mental health liaison worker was also able to see patients at the practice. Patients at risk of dementia were flagged on the practice computer system and during annual reviews were asked if they had concerns about their memory, which could then be assessed. Patients had access to the 'living well with dementia' team and the dementia crisis team to provide extra support.

The practice had a register of housebound patients. The register ensured the practice was aware when these patients had medicine requests, required home flu jabs, annual reviews or care planning. The practice also supported patients at several care homes. Staff told us that new patients of the care homes had a review of their care within 10 days of their registration with the practice. Carers were highlighted on the practice's computer system and were given information about the local carers support team.

The practice supported patients with complex needs and those who were at risk of hospital admission. The practice worked closely with the local proactive care team which included district nurses, community matron, physiotherapists, occupations therapists and pharmacists. Personalised care plans were produced and were used to support people to remain healthy and in their own homes. Patients with palliative care needs were supported using the Gold Standards Framework. The practice had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term condition had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition and worked with community matrons, district nurses and proactive care team to provide support. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required.

The practice provided equality and diversity training through on-line training. The practice had a number of policies for quality and diversity including a patient dignity charter and information was on display for patients in relation to zero tolerance to racism.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floor of a purpose built building. There was a stair lift which allowed access to the first floor. We noted patients had access to the front entrance of the practice via a slope and doors which had an automatic opening mechanism. Patients with restricted mobility could easily enter the practice and had level access to

Good

Are services responsive to people's needs?

(for example, to feedback?)

reception. The waiting area was accessible for wheelchairs and mobility scooters. Accessible toilet facilities including baby changing facilities were available for all patients attending the practice.

Access to the service

Appointments were available from 8.30am to 6.30pm on weekdays. The practice operated an 'urgent only' phone service from 12.30pm to 1.30pm and from 5.30pm to 6.30pm. There was a late evening surgery on a Monday from 6.00pm to 8:00pm. The practice was also able to offer four pre-bookable appointments on a Saturday which was on a rota basis with other local practices. Phone lines to the practice closed during lunch however there was an emergency phone number available for patients if required. We also noted the practice itself remained open and patients could attend the practice to make appointments or request / pick up repeat prescription during this time.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits could be arranged and GPs visited several local care homes and a residential home for people with dementia, learning, sensory and or physical disabilities.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

We noted data from the national patient survey 2013 indicated that 100% of respondents said the last appointment they got was convenient**.** On the day of inspection we asked staff when the next available appointment would be for an emergency and a cervical screening. The appointment system showed that there was an emergency slot free for that day but staff informed us that the duty doctor would also be available if the patient wanted to talk to a GP first. We noted that the next cervical screening appointment with the nurse was for the following day.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand how to make a complaint. There were posters in the waiting room to describe the process should a patient wish to make a compliment. Information was also advertised on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found these were all discussed, reviewed and learning points noted. We saw these were handled and dealt with in a timely way. We noted that lessons learned from individual complaints had been acted on. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff. The culture of the practice was that of openness and transparency when dealing with complaints and the practice tried to encourage patients to share their opinions. We saw that on the patient newsletter the practice kept patients informed of practice information and asked patients to respond with ideas or concerns. For example, the recent refurbishments and disruptions to the waiting area.

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 care and promote good outcomes for patients. We found details of the vision and practice values in their statement of purpose. The practice vision and values included providing high quality clinical care and customer service and supporting the professional development and personal wellbeing of their staff. The vision also included a focus on continuous improvement in the quality of their services, in a safe environment, within an atmosphere of respect and appreciation of each individuals' contribution to the practice.

We spoke with 16 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about the practice and thought that there was good team work. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. Many of the staff had worked at the practice for a number of years and all the staff we spoke with were positive about the open culture.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of these policies and procedures and found these had been reviewed annually, were up to date and contained relevant information for staff to follow. This included medicine management, whistleblowing, complaints, equality and diversity, chaperoning and infection control.

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 a GP partner was the lead for safeguarding. We spoke with 16 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, coil audit, ADHD medication and reviews of services or referrals made to other organisations.

The practice had robust arrangements for identifying, recording and managing risks. The business manager showed us risk assessments, which addressed a wide range of potential issues, such as infection control, fire, the use of the practice wheelchair and the control of substances hazardous to health (COSHH) .

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. QOF data was discussed at monthly team meetings to maintain or improve outcomes. The practice held regular meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were weekly management and clinical meetings. Staff told us they had weekly one to ones with their senior team members which gave them the opportunity to discuss issues, concerns or give feedback to the practice. There was an open culture within the practice and staff told us they were happy to raise issues and felt encouraged to do so. Staff told us that social events had been arranged by the practice. These events were used for senior staff members to thank staff for their work and provided an opportunity for reflection.

We saw there were a number of human resource policies and procedures in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and knew the GP partners would take their concerns seriously and support them. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice did not have an active patient participation group (PPG). The PPG had been active in the past but struggled to find patient representatives. Staff told us that the practice was in the process of trying to re-start the group and we saw that the PPG was being advertised in the newsletter, notice boards and through the practice website. Instead the practice had gathered feedback from patients through patient surveys, a suggestion box and compliments and complaints received.

We looked at the results of the annual patient survey from March 2014. We saw that patients had commented on several areas including the waiting room being uninviting and the sharing of practice information. We noted that the waiting room had been refurbished and that the practice now had a practice newsletter which shared relevant practice information with its patients. We also saw that the TV information screen contained practice information and that there was a new patient pack.

The practice had gathered feedback from staff through staff discussion, meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, nurses we spoke with told us they had discussed separate dressing appointments and had recommended that this be replaced with a dressings clinic in order to help with time management for patients and staff. We saw that clinics were now run routinely although when necessary individual appointments could still be made.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included reviews from colleagues and a personal development plan. Staff told us that the practice was very supportive of training and that they had regular training either organised with the local clinical commissioning group or by the practice.

The practice was a GP training practice and supported new registrar doctors in training. At the time of the inspection the practice had two GP registrars. One of the GP partners supervised the doctors at all times.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, we noted that a staff member had reported a needle stick injury. The practice investigated the event and ensured that staff were working to best practice protocols and developed a new policy for staff to follow.