Ash Trees 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Ash Trees Surgery on 14 October 2014. The inspection was scheduled as part of our new comprehensive inspection programme and was announced to the practice.

The practice operates branch surgeries in Bolton-le-Sands, Silverdale and Halton. These services were not inspected as part of this visit. However, we did leave CQC comment cards at each location and invite patients to provide us with feedback.

A merger between Ash Trees Surgery and a practice in Arnside came into effect on 1 October 2014 but at the time of inspection the practices continued to operate under separate contracts with the Clinical Commissioning Group and maintained separate patient lists. The Arnside practice was not therefore considered as part of this inspection.

The practice is registered with the CQC to the provide the following regulated activities:

- Diagnostic and screening services
- Family planning
- Maternity and midwifery
- Surgical procedures
- Treatment of disease, disorder or injury

Our key findings were as follows:

- The practice was rated as requires improvement for safe
- The practice was rated as good for effective
- The practice was rated as good for caring
- The practice was rated as good for responsive
- The practice was rated as good for well led

We saw several areas of outstanding practice including:

- The systems in place to help patients/carers support emotionally with care and treatment
- The systems in place for working with colleagues and other services in response to bereavement.

The provider should:

Summary of findings

- Implement actions to improve aspects of the service identified during inspection and detailed in this report. For example, the systems in place to prevent and control infection, records in relation to staff training, staff knowledge of the requirements of the Mental Capacity Act 2005, a register of carers and policy on patient consent.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong thorough reviews and investigations were undertaken. Lessons learnt were communicated widely to support improvement. However, some of the potential risks to patients who used services were not assessed, for example, in relation to health and safety. Where systems and processes existed to address risks, such as the practice policy on infection prevention and control, they were not always implemented to ensure patients were kept safe. The medicines management procedures to be followed were not always documented to provide staff with clear instruction and guidance. Improvements were required to ensure there were effective systems to regularly assess and monitor cleanliness and infection prevention and control.

Are services effective?

Good

The practice is rated good for effective. Data showed the patient outcomes were at or above average for the locality. People's needs were assessed and care was planned and delivered in line with current legislation. This included promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had systems in place for appraisal and personal development of staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed the practice rated higher than others for certain aspects of care. For example, the percentage of patients who had comprehensive care plans documented and agreed with individuals, family and/or carers as appropriate. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. The practice had outstanding arrangements in place to offer patients/carers support to cope emotionally with care and treatment, for example, The Listening Service. We 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 responsive. The practice reviewed the needs of their local population and engaged effectively with the

Summary of findings

NHS Local Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to appointments. GPs maintained personal lists offering patients continuity of care. Urgent same day appointments were available as required. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to delivery this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. The practice planned for succession. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients which included use of technology. The practice had a patient participation group and future plans included further development of this.

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. The practice had a significantly greater proportion of older people within its patient population than the national average. They offered proactive personalised care to meet the needs of patients and had a range of enhanced services, for example end of life care. The practice was responsive to the needs of older people, including offering home visits to patients living independently. The number of patients within the practice population living in nursing/residential homes also exceeded the national average. GPs carried out scheduled home visits to these patients.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Longer appointments and home visits were available if required. GPs maintained personal lists so each patient had a named GP. Systems were in place to carry out structured annual reviews to check patients' health and medication needs were being met. Where patients had complex health needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place to highlight vulnerable patients on the electronic records. The practice held quarterly multi-disciplinary meetings with health visitors in relation to safeguarding issues, including consideration of looked after children. Immunisation rates were relatively high for standard childhood vaccinations. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people (including those recently retired and students). Patients were able book appointments and request repeat prescriptions

Summary of findings

using on line services and the practice offered appointments with GPs and nurses during extended hours. A range of health promotion and screening services were available which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. A register was maintained of those patients with learning disabilities. Care plans were developed to support patients and the practice carried out annual health checks. Extended appointments were arranged and the practice worked in conjunction with the local authority learning disability team to follow up on any non-attendance. The practice offered a minor injury service for both registered and non-registered patients. Systems were in place to notify a patient's usual GP in a timely manner if a non-registered patient had required treatment.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for the population group of people experiencing poor mental health (including people with dementia). Registers of people experiencing poor mental health were maintained and patients had annual health checks. The practice was a pilot site for easy access to mental health which promoted self-referral to counselling.

Summary of findings

What people who use the service say

We received 24 completed CQC comment cards or letters. The majority of patients spoke positively about the care and treatment they received. We received responses from people who attended both Ash Trees and the branch surgeries. We received feedback from males and females and that they included patients who had experience of mental health issues, mother and baby services, and had long term conditions such as diabetes. People told us they felt listened to and involved in planning their care and treatment. They told us they were treated with dignity and respect.

Three of the responses were less positive. Criticism centred around accessibility and difficulties experienced in getting appointments.

Areas for improvement

Action the service SHOULD take to improve

- There was no risk assessment regarding control of substances hazardous to health.
- There was no central record of staff training. The proposed practice policy in relation to staff training had not been implemented.
- There was no practice policy in relation to patient consent.
- Staff were not trained in the requirements of the Mental Capacity Act 2005.
- The practice did not maintain registers of patients who have carer responsibilities and require carer support.

- **Infection prevention and control:**

- Clinical waste had not been placed into appropriate bins. Clinical waste sacks were not securely tied when three quarters full and stored in a designated area. This breached the practice infection prevention and control policy.
- The child sized oxygen resuscitation masks had been opened.
- Quality assurance checks undertaken by the practice to verify appropriate standards of cleanliness and infection prevention and control measures are met were not documented.

- **Medicines management:**

- GPs were not able to electronically access warfarin test results held by the local NHS Trust. They were not always aware of a patient's latest test result before further prescribing.
- Patient Group Directions were not signed by the practice's authorising manager before patients presented for treatment.
- There were no documented practice policies and procedures describing medicines management.

Outstanding practice

- The systems in place to help patients/carers support emotionally with care and treatment. The practice offered patients access to The Listening Service. This was a free, confidential service facilitated by a volunteer chaplain listener on a weekly basis. Appointments were available for patients who felt they would benefit from an opportunity to discuss their concerns empathetically, for example, illness, the prospect of surgery, difficult diagnosis and bereavement. Appointments could be made at the suggestion of a GP, nurse or team member, or on the patient's own initiative.

Ash Trees Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP, CQC pharmacist inspector and a practice manager specialist advisor.

Background to Ash Trees Surgery

Background to Ash Trees Surgery

Ash Trees Surgery is located in Carnforth and is part of the North Lancashire Clinical Commissioning Group. There are branch surgeries in Bolton-le-Sands, Silverdale and Halton. The total patient population is 14869.

Over the past four months the practice has experience major changes. Three longstanding GP partners have retired and three members of the nursing team have moved on. New staff have been recruited but some vacancies exist. A new practice manager joined the team in June 2014 with a remit that included additional responsibilities in coordinating the imminent merger of Ash Trees Surgery with a practice in Arnside. The merger came into effect on 1 October 2014 but at the time of inspection the practices continued to operate under separate contracts with the Clinical Commissioning Group and maintained separate patient lists. The Arnside practice was not therefore considered as part of this inspection. Business plans in relation to the merger anticipate continued activity in this regard over the next eight months.

The staff team currently comprises of seven partner and five associate GPs. This includes both males and females. Working alongside the GPs are a practice manager and deputy, an advanced nurse practitioner, five nurses, four primary health care support workers, and a team of patient advisors and clinical auditors. The practice is a dispensing practice and employs a pharmacist and dispensing manager. In total there are 47 permanent and two temporary members of staff.

Ash Trees Surgery is a training practice for doctors who wish to become GPs. A Registrar and a medical student were attached to the practice at the time of inspection. One of the GP partners is a qualified trainer.

The practice population includes a lower number (19%) of people under the age of 18, and a significantly higher number (25%) of people over the age of 65, in comparison with national averages. There are comparatively low levels of deprivation in the practice area.

Surgery opening times at Ash Trees are between 8am and 6.30pm Tuesday to Friday. On Mondays the surgery remains open until 8.30pm. Surgery hours at the branches are more restricted. When the surgery was closed the care and treatment needs of patients were met by an out of hours provider, Bay Urgent Care.

The practice was inspected by the CQC in December 2013 under our previous methodology and judged to be compliant.

Why we carried out this inspection

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

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

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

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

How we carried out this inspection

How we carried out this inspection.

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew. The information reviewed did not highlight any areas of risk across the five domain areas. We spoke with a representative of the Patient Participation Group and the Registrar by telephone.

We carried out an announced visit on 14 October 2014 and spent nine hours at Ash Trees Surgery. We did not visit branch surgeries as part of this inspection. Before the date of inspection we suggested the practice may wish to deliver a short presentation to tell us what they thought they did well in each of the key questions and what they were doing to improve those areas that were not so good. Partners and members of the senior management team took the opportunity to do so.

During our visit we spoke with a range of staff including GPs and trainees, the practice manager and deputy, nurses and primary health care support workers, dispensary staff, members of the patient advisor and clinical audit teams. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available at Ash Trees Surgery and all branches prior to inspection.

Requires improvement

Are services safe?

Our findings

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients. The practice manager was aware of their responsibilities to notify the Care Quality Commission about certain events. For example, if there was an occurrence that would seriously reduce the practice's ability to provide care.

Arrangements were in place to identify patients who required annual reviews of on-going care and treatment to ensure it continued to be safe and effective.

Care and treatment was provided in an environment that was well maintained. Appropriate arrangements were in place with external contractors for maintenance of the equipment and building.

The practice had limited systems in place to identify, assess and manage risks relating to health and safety. For example, no risk assessments had been completed in relation to the control of substances hazardous to health. During the initial presentation the practice told us they had identified a need to improve their systems in this regard and gave assurances they intended to do so. The senior team were due to receive health and safety training on 13 November 2014.

Learning and improvement from safety incidents

The practice had an effective system in place for reporting, recording and reviewing significant events. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Lessons learned were extracted and shared with staff through team meetings. This helped ensure the practice maintained a regime of continuous improvement.

Reliable safety systems and processes including safeguarding

The practice had policies in place in relation to safeguarding vulnerable adults and children. These were readily accessible to staff on the practice intranet. Staff we spoke with confirmed their awareness of them. One of the GP partners acted as a safeguarding lead for the practice. They were supported by two other designated members of staff.

There was a system in place to highlight vulnerable patients on the practice's electronic records. This included a cause for concern code for at risk children. The practice held quarterly multi-disciplinary meetings with health visitors in relation to safeguarding issues, including consideration of looked after children.

Notices were displayed around the practice advising patients they could have a chaperone present during their consultation if they wished. When a chaperone was requested the role was fulfilled by nurses or primary health care support workers who had been trained in this regard. The practice chaperone policy provided appropriate guidance and instruction to staff to carry out this role.

Medicines Management

We saw that requests for repeat prescriptions were dealt with in a timely way. Arrangements were in place to ensure that changes to patients' medicines for example, following a hospital stay, were reviewed by the practice pharmacist or a doctor and uplifted to the practice's electronic record. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that prescribed medicines always reflected patients' current clinical needs. All prescriptions were signed by a GP or the pharmacist prescriber before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

However, we found that procedures were not in place for GP's to be made promptly aware of the results of patients' INR tests (anticoagulant blood tests). Contrary to NPSA (National Patient Safety Agency) guidance the latest result was not confirmed before prescribing anticoagulants for housebound patients. The practice manager told us that this was being discussed at Clinical Commissioning Group (CCG) level.

Vaccines were administered by nurses using Patient Group Directions (PGDs) that had been produced line with national guidance. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation

for treatment. However, these had not been signed by the practice's authorising manager. It is the responsibility of the authorising manager to ensure that all staff using the PGD are competent to do so.

We looked at records to see if medicines requiring refrigeration had been stored appropriately. Recent records had been completed and showed these medicines had been held within the accepted temperature range, and so were safe to administer.

The practice operated a Doctor Dispensing Service from inside the registered community pharmacy located at the practice. Professional support was provided to the dispensary staff by both the practice pharmacist and the community pharmacist. The practice had a system in place to assess the quality of the dispensing process and they had previously signed up to the Dispensing Services Quality Scheme (DSQS). However, a DSQS submission was not requested and assessed by NHS England Lancashire for the last financial year.

We saw evidence that support was provided to the surgery from the practice pharmacist who was also the CCG pharmacist. The pharmacist was involved in reviewing data about prescribing, medication reviews and current practice at the surgery. However, comprehensive written policies and procedures describing medicines management at the surgery were not available to help ensure consistency in practice.

Cleanliness & Infection Control

On two of the CQC comment cards we received patients told us the practice was always clean and hygienic. The practice appeared clean and tidy with the exception of carpets to the upstairs waiting area which were visibly stained.

The practice employed in-house cleaners. Their job descriptions included schedules detailing the tasks to be completed and the frequency with which they should be done. There were no records to show when tasks had been completed or evidence continuity of infection control measures. Neither were there any records to show the practice regularly carried out quality assurance checks to satisfy itself appropriate standards were being met

One of the GPs led on infection prevention and control within the practice, supported by two other designated members of the team. The practice had an infection control and prevention policy in place which had last been reviewed in September 2014. The policy was brief and referred to a number of supplementary protocols providing detailed guidance on issues such as hand wash procedure, dealing with spillage involving blood or bodily fluids, and needle-stick injury. Staff showed us the protocols were readily accessible on the practice intranet.

The practice had completed an infection prevention and control audit in March 2014. A number of actions had been identified and timescales set for completion. We found that some actions had been completed but others remained outstanding although the date for completion had passed.

The systems in place for collection and segregation of clinical waste were not robust. For example, we found a full sharps bin in the store room which should have been removed within two weeks of being placed there. The bin was dated June 2014. We found clinical waste bags stored in a recess next to the main vaccine fridge. This was a breach of the practice policy which required that clinical waste must be placed in appropriate bins provided in each surgery and sacks must be securely fastened when three quarters full and stored in a designated area.

Supplies of personal protective equipment including disposable gloves and aprons were available to staff to use.

Hand hygiene technique signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and paper hand towel dispensers were available. We noted that supplies of hand gel were restricted to the toilets and not strategically placed around the practice to promote hand hygiene.

We looked at five of the clinical rooms, including the room used for minor operations. On the door to the minor operations room a sign was clearly displayed advising the room must not be used for the changing of dressings. All the rooms were visibly clean. Nurses were responsible for maintaining infection prevention and control measures within the treatment rooms they worked in throughout the day. There were systems in place to check adequate levels of stock were maintained in all clinical rooms, for example, of personal protective equipment.

Equipment

Staff told us they had sufficient equipment to enable them to carry out examinations, assessments and treatments. Records confirmed equipment was tested and maintained regularly. We saw evidence portable electrical equipment was routinely tested. Stickers were displayed on items

indicating the last test date. We saw evidence of calibration of relevant equipment, for example the sphygmomanometer, an instrument used for measuring blood pressure.

Staffing & Recruitment

We looked at the recruitment records of staff employed within the last four months. Records contained evidence to demonstrate appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The recruitment process included questions to establish that people were physically and mentally fit for the work.

In September 2014 the practice had introduced a new criminal convictions, disclosure and barring service policy and risk assessment. The policy stated that all GPs and health care professionals who worked with patients on a one to one basis must have disclosure and barring service clearance to verify they were of good character. All other staff were required to sign a criminal convictions disclaimer. We saw evidence that work was in progress to implement the policy. The practice manager had systems in place to check clinicians maintained medical indemnity insurance.

Monitoring Safety & Responding to Risk

Each day one of the GPs was on call and available to speak with patients by telephone and see patients attending for emergency appointments. Same day appointments were available all day for any patient who required one.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well being or medical emergencies. For example, there were regular reviews in relation to palliative care with updates provided to out of hours providers.

Systems were in place to ensure the number and skill mix of staff available was sufficient to meet patients' needs. The practice operated a rota system for the different staffing groups to ensure there were sufficient staff on duty at each of the branches. Patient advisors were trained to cover a variety of roles, for example, reception and call handling. Members of staff covered each others leave. A recent audit of the nursing team had identified it was understaffed. As a result additional staff had started to be recruited.

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, a nebuliser and a defibrillator. A nebuliser is a device that converts liquid into aerosol droplets suitable for inhalation. A defibrillator may be used to attempt to restart a person's heart in an emergency.

We noted the packaging on the child sized oxygen resuscitation mask had been opened. We brought this to the attention of the practice manager who assured us a replacement would be ordered immediately.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those medicines used for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice had recently carried out an audit of emergency medicines and plans were in place to up-date the medicines kept in line with national guidance.

A business continuity plan was prepared in August 2014. It set out how the practice would respond to a range of emergencies that may impact on its daily operation. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to.

Staff were up to date with fire training and systems were in place to regularly test the fire alarms and equipment. Fire alarms and extinguishers were placed throughout the building and checks were in date. Fire exits were well signposted and free from any hazards to prevent escape in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs had particular areas of accountability in which they led the practice. For example, prescribing and medicines management, liaison with the Clinical Commissioning Group and Local Medical Committee. Their responsibilities included dissemination of relevant information to colleagues to ensure the practice remained up to date and operated within current best practice guidelines. There were clear systems in place to ensure information was shared effectively.

The practice employed an advanced nurse practitioner who held additional qualifications enabling them to diagnose and prescribe in relation to certain new and acute problems. Members of the nursing team had special areas of interest in which they had achieved additional qualification. For example, asthma, heart disease, diabetes, heart failure, travel vaccination and family planning. The nursing team delivered timely and appropriate care to patients by running clinics to monitor and manage on-going conditions.

Each new patient registering with the practice was offered a health check with a primary health care support worker. These were tailored to meet the needs of the patient and might include, for example, blood pressure check, weight and lifestyle advice. The GP was then informed of any health concerns highlighted and these were promptly followed up. For example, through GP consultation and referrals to in house clinics for on-going management

The practice operated a triage system to handle appointment requests. This ensured patients were directed to the most appropriate person to meet their care and treatment needs effectively and in a timely manner. Calls were initially taken by patient advisors who had been trained in triage.

There were systems in place to ensure referrals to secondary care were made in line with national standards. GPs audited each others referrals for consistency and appropriateness.

Management, monitoring and improving outcomes for people

We looked at examples of some of the clinical audits carried out within the last 12 months. Examples included an audit completed by year five medical students, supported by a GP partner, to check that all relevant information was being documented in relation to patients receiving warfarin. The audit showed this was not consistently the case. We saw evidence that actions were identified to address this, shared with colleagues, and implemented. A further audit was then completed to confirm the problem had been satisfactorily resolved.

One of the nurses, who led the practice in relation to contraception, completed an audit of coils and implants inserted and removed over a specified period with a view to identifying any common reasons for removal or complications with the procedure. No recommendations were required.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. Systems to follow up and recall patients if they failed to attend appointments were robust, for example, non-attendance at a child vaccination clinic or annual review for a patient with learning difficulties.

The Quality and Outcome Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF awards practices achievement points for management of common chronic diseases, how well the practice is organised, patients' experience and the amount of extra services the practice offers. The practice had a dedicated clinical audit team. Their role included analysis of data with a view to identifying potential areas for improvement and assessing practice performance against QOF. The clinical audit team collated information and used it to support the practice by carrying out clinical audits. The team had recently audited information with a view to reducing unplanned admissions to hospital. Data had been scrutinised to identify patients at risk of emergency admission, for example, due to chronic conditions or frailty. Staff had then set about implementing plans to minimise risk of emergency admissions. For example, creation of care plans, medication reviews, ensuring carers were in place and documentation regarding powers of attorney were in order. We were told that, as a result of information highlighted from this audit, the practice had achieved the national target of 2.2%.

Effective staffing

Practice staffing included medical, nursing, managerial, dispensing and administrative staff. At the time of

Good

Are services effective?

(for example, treatment is effective)

inspection the practice had vacancies for one GP and one nurse practitioner and were actively seeking to recruit. We saw evidence that, where possible, the practice tried to plan for succession, for example, where it was known a member of staff was due to retire evaluation and early recruitment planning took place. Despite recruitment challenges the practice had managed to maintain levels of service to meet patient need.

The practice manager had only been in post since June 2014. Prior to their arrival, individual members of staff had maintained records of their training and the practice did not have a comprehensive overarching record. The practice manager had introduced a system to rectify this. Individuals were now required to produce evidence of training completed to the finance manager so it could be recorded on a central database. We saw evidence that this was work in progress.

The practice manager showed us a training policy drafted in July 2014. This was due for ratification in October 2014 and had yet to be implemented. The policy was comprehensive and included clarification of the mandatory training requirements for members of staff, the frequency with which refresher training in particular subjects should be completed and the rationale for this decision.

All staff had access to an e-learning tool that included training on subjects such as information governance, confidentiality, safeguarding, health and safety. Some role specific training was being organised for individual members of staff. Two nurses were due to attend an update on cytology and one nurse a family planning course in the near future.

Clinical and non-clinical staff who had been employed for some time confirmed they had always had annual appraisals with their line manager. These had included discussion about training and personal development. The new practice manager assured us annual appraisals would continue.

GPs must meet the requirements of the national GP revalidation scheme operated by their governing body, the General Medical Council. Revalidation is the process by which doctors demonstrate they are up to date and fit to practice. As part of the revalidation process GPs must have annual appraisals carried out by approved GP appraisers.

GPs told us the practice supported them through the appraisal process. They were able to draw upon learning from clinical meetings in compiling their appraisal portfolios.

Working with colleagues and other services

There were effective systems in place to deal with incoming post. The clinical audit team prioritised scanning, coding and distribution of incoming daily post on receipt to make it available for review by clinicians at the earliest opportunity, for example, hospital discharge letters.

The practice operated a buddy system whereby GPs covered urgent work for colleagues during periods of absence to ensure it was dealt with in a timely manner. For example, incoming blood test results were allocated to another GP for review if the patient's named GP was on leave. The buddy system extended to palliative care patients so they had continuity of care across two or three GPs.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, updating the out of hours service in relation to patients receiving palliative care and liaison with the local authority learning disabilities team to notify them if a patient had failed to attend a review.

The practice had devised a prompt sheet for handling bereavement. This set out the steps to be followed by staff to ensure that the relevant agencies, for example Macmillan nurses, received timely notification of death to avoid risk of further distress to relatives.

The practice benefitted from an in house pharmacy which stocked a range of goods for sale including over the counter medicines. Patients were able to use the in house pharmacy to obtain their prescriptions if they wished.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals to secondary care.

There were systems in place to provide staff with the information they needed. An electronic patient system was

Good

Are services effective?

(for example, treatment is effective)

used by all staff to coordinate, document and manage patients' care. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We were told that there were plans underway for the pharmacist to have shared access to parts of the clinical records relevant to their role in carrying out medication reviews in the near future.

The practice shared policies and procedures with staff through their intranet. We saw the system included a search facility enabling staff to search against subject of choice.

Consent to care and treatment

There was no written policy in place regarding consent to guide staff in supporting patients to make their own decisions regarding care and treatment and how such decisions should be documented in the medical notes. However, we did see evidence of good practice in obtaining consent to treatments. At the time of our inspection the practice was actively promoting the availability of flu vaccinations. We saw that consent forms were in place and being used by health care support workers to record that patients attending flu clinics consented to vaccination.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. Care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it.

The practice had not reviewed the Mental Capacity Act 2005 (MCA) and had not ensured all staff had understanding of it. The MCA is designed to protect people who are unable to make decisions for themselves or lack the mental capacity to do so.

Health Promotion & Prevention

New patients joining the practice were asked to complete a health and wellbeing questionnaire. Patients were asked about matters such as their medical history, current medication, allergies, chronic conditions and family history. Information about social and lifestyle issues such as smoking, alcohol use and carer support was also requested to inform the practice of the needs of its patients.

The practice offered a range of services aimed at health promotion and prevention. Examples included women's health checks, dietary advice and smoking cessation. A wide range of information was available to patients. There were several noticeboards in the practice which displayed information on health and well being topics. We saw there was general guidance to promote good health, together with information about specific conditions and signposts to support organisations.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in 2013. This showed the practice was rated in the middle range for the proportion of patients who would recommend their GP surgery. The practice was also rated in the middle range for the proportion of patients who rated as good or very good their overall experience in making an appointment to see or speak with a nurse or GP.

Prior to inspection we asked the practice to make CQC comment cards available at all branches inviting patients to provide us with feedback on the practice. We received 24 completed cards or letters and the majority were positive about the service experienced. Patients said the staff were helpful, friendly, professional and kind. This was consistent with our observations on the day. They told us they were treated with dignity and respect. Patients told us the care and treatment they received was excellent, faultless, exemplary and very good. Three of the comment cards were less positive in relation to availability of appointments.

Consultations and treatments were carried out in the privacy of a consulting room. We noted that doors were closed during consultation and conversations could not be overheard. Doors were lockable and curtains were provided around consultation couches so that patients' privacy and dignity could be maintained during examinations.

Clinicians came through to the waiting areas to call patients for their consultation. We observed that in doing so they greeted people in a warm, friendly and polite manner.

We observed staff working on the reception desk. The nature of the building was such that conversation could be overheard. Most incoming calls to the practice were taken in the general office away from the reception area but during quiet periods at reception staff there also helped take calls. We noted that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The two members of reception staff sat at opposite ends of the reception desk minimising the risk of patients attending the desk overhearing potentially private conversations between another patient and reception staff. Staff told us there was usually at least one treatment room kept free and if a patient requested to speak with reception in private they would use the room for that purpose.

Care planning and involvement in decisions about care and treatment

On the CQC comment cards we received patients spoke positively about their involvement in planning and making decisions about their care and treatment. Patients told us GPs respected their views and were patient in going through the pros and cons, and long term implications of any agreed actions. The feedback we received included comments from patients with experience of treatment and care in relation to pregnancy, diabetes and mental health. They confirmed that they felt involved in decisions, options were fully explained and their views were listened to.

Patient/carer support to cope emotionally with care and treatment

The practice offered patients access to The Listening Service. This was a free, confidential service available to anyone over 18 facilitated by a volunteer chaplain listener. The chaplain attended the practice each Wednesday and appointments were available for patients who felt they would benefit from an opportunity to discuss their concerns empathetically, for example, illness, the prospect of surgery, difficult diagnosis and bereavement. Staff told us the service had proved very popular. Appointments could last up to 50 minutes and could be made at the suggestion of a GP, nurse or team member, or on the patient's own initiative. Literature advertising the service was available in reception.

Representatives from Help Direct also held weekly clinics at the practice. Help Direct is a support and information service for adults over aged 18 which seeks to help people get practical support, information and advice before a problem becomes a crisis. For example, with issues relating to health and fitness, mobility and transport, community groups and involvement, and managing finance. Appointments were available through the practice reception.

We saw that the practice had a protocol in place to ensure bereavement was handled effectively and with sensitivity. In addition to the entries placed on individual patient's records a list of recent deaths was maintained in the general office providing staff with an immediate visual prompt to assist them in handling calls. Following a death

Good

Are services caring?

the GP who had the most recent involvement with the patient would visit the next of kin. Staff described the bereavement visit as a 'caring' visit to express sympathy and provide next of kin with practical information to help them in dealing with their loss. For example, registering the death and making funeral arrangements. The information pack also contained leaflets about support groups that may be of help to them, for example Child Bereavement UK and Help Direct.

There was a wide range of notices and leaflets available in the waiting areas signposting patients to support groups and organisations, for example, in relation to self-harm, smoking, diabetes, Parkinson's disease, cancer and memory loss.

The literature available included information aimed at carers. The practice did not have a protocol in place to actively identify patients who had carer responsibilities or required carer support. When a carer was identified this was recorded on the clinical notes but the practice did not maintain a dedicated carer list.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a good understanding of the demographics of people in the area it provided services to. One GP led on communication with the Clinical Commissioning Group (CCG), reviewing and disseminating incoming information appropriately. An effective communication system was in place between the practice and its commissioners, contributing to implementing changes in patient care when appropriate.

The major staffing changes over the past four months had necessitated some patients being allocated to a different GP either on a permanent or buddy cover basis. Staff consistently told us continuity of patient care was a priority. It was clear the practice strived to maintain this as far as possible throughout the changes. One retired GP had returned to work as a locum during this transitional period which helped in this regard.

The clinical audit team maintained a number of patient lists. For example, patients with learning disabilities, dementia and diabetes. There were good systems in place to ensure care and treatment was regularly reviewed to check it continued to be effective.

The practice offered a good range of services in house to meet the needs of the patient population including management of chronic conditions, such as, asthma, coronary heart disease, diabetes, blood tests, wound care, well baby and child development clinics, and vaccinations.

There were a number of large care homes in the area with residents registered at the practice. GPs carried out scheduled home visits to these locations.

At the time of inspection the practice was involved in a pilot for easy access to mental health. This involved promotion of self-referral to counselling.

The practice was proactive in utilising the staff skills resource available and promoting further staff development to best meet identified needs of the patient population. For example, practice nurses were having additional training in relation to family planning and chronic obstructive pulmonary disorder (COPD). Primary health care support workers had received training to enable them to assist with the delivery of flu vaccinations and provide simple dressings. One of the newer members of nursing staff had previous experience in tropical medicine and hospital accident and emergency work. They were utilising this to review emergency drugs and care, and further develop travel clinics. Two nurses had diabetes diplomas and were qualified to commence patients on insulin. Staff told us there was a meeting planned in the near future to discuss the introduction of diabetes screening in high risk groups as this was an additional service they were keen to introduce.

The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs led on this. They had a palliative care register and held regular internal and multi-disciplinary meetings to discuss the care and support needs of patients and their families. Systems were in place to provide regular updates to the out of hours service.

Wherever possible requests for home visits were met by the patient's named GP. The GP listed to be on call for the day responded to requests where this was not possible.

Tackling inequity and promoting equality

Most GPs held surgeries at more than one of the branches. Patients were able to make appointments at the location most convenient for them. The practice manager told us geographical considerations had been taken into account when GP personal lists were reviewed to maximise accessibility to the service.

The computer system enabled staff to place an alert on the records of patients who had particular difficulties so the GP could make adjustments. For example, carer support, learning or hearing difficulties. Longer appointment times were available for patients who required them.

There were systems in place to overcome barriers to communication. In the reception area a portable hearing induction loop available. Patients attending for appointments could use an automated check in to alert reception to their arrival. This offered a range of language options. Staff told us that translation and signing services during consultation could be arranged as required.

Ash Trees Surgery was on two floors with consultation and treatment rooms on each. No lift was available. The practice arranged for consultations to take place on the ground floor if patients were unable to manage the stairs. Notices were displayed in the waiting area advising patients of this. We were told there could be some delay in a patient being seen if the practice was not notified this

Good

Are services responsive to people's needs?

(for example, to feedback?)

would be necessary in advance of the appointment. There was good wheelchair access to ground floor rooms. Corridors were wide and the waiting area spacious. Accessible toilet facilities were available for all patients and included baby change facilities.

The practice operated a minor injuries service which was available to both registered and non-registered patients. Systems were in place to register a visitor on temporary basis in order that they might access the service as necessary. An advisory notification was sent to patient's usual practice to ensure continuity of care.

Access to the service

Ash Trees Surgery offered appointments over extended hours. The practice was open from 8.00am until 8.30pm on a Monday, and from 8.00am until 6.30pm Tuesday to Friday. The practice patient information leaflet advised they were hoping to further increase the range of appointments available outside normal surgery hours in 2015. Opening hours at branch surgeries were more restricted. There was comprehensive information on the practice website to explain the various opening hours, how to book home visits, emergency appointments and the out of hours arrangements.

Patients could book appointments with their own GP in person, by telephone or on-line at the Ash Trees, Bolton-le-Sands and the Halton branches. There were eight incoming telephone lines to receive calls. At Silverdale the practice ran an open access surgery where no appointment was required and patients were seen in order of arrival.

Data from the national patient survey 2013 showed that the practice was rated in the middle range for the proportion of patients (78.3%) who rated their overall experience of making an appointment as good or very good. The proportion of patients who rated the practice opening hours as good or very good was 82.6% which meant in it achieved the expected level.

Listening and learning from concerns & complaints

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

Information was available to help patients understand the complaints system. The practice had produced a leaflet explaining the complaints procedure and copies of this were available in reception. The complaints procedure was also referred to on noticeboards within the practice and on the website.

We looked at three of the complaints that had been received since March 2014. They had been handled appropriately and in a timely manner. Patients had been invited to attend face to face meetings to discuss matters at the earliest opportunity.

The practice reviewed complaints annually to detect themes or trends. The last report that had been prepared for the period 1 April 2013 to 31 March 2014. Complaints had been analysed by both subject and service area. Where complaints had been upheld there had been discussion with staff and advice given to learn from the incident and prevent recurrence.

A number of compliments had also been received over the last few months. These had been shared with the practice team.

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. The practice had recently developed a mission statement. This was 'To provide an excellent standard of medical care to our community delivered with competence and compassion. To ensure a supportive and safe working environment for the whole practice team'. Staff had been fully involved in the development of this. The mission statement was well publicised and appeared on noticeboards within the practice and on the website.

At the time of our inspection the practice was in the process of merging with another. There were comprehensive business plans in relation to this. All aspects of the project had been risk assessed and prioritised. Senior management had identified areas for future improvement by way of on-going development. The process had begun in July 2014 and was likely to continue over the next eight months. Partners were holding weekly non clinical business meetings to monitor and review progress on the practice merger.

The practice was participating in the Clinical Commissioning Group and Morecambe Bay Better Care Together Programme. This is a review of health services with a focus on integrated team working to promote more cohesive community and social care. Further work was being undertaken to develop wider self-care aspects within the practice.

Governance Arrangements

The practice structure and reporting lines were clearly defined. Each partner had key areas of accountability which included finance, information governance, human resources, estates and partnership meetings. They were supported in fulfilling these responsibilities by named members of staff. Agreed accountabilities had been documented and shared with staff. These had been updated in a timely manner to reflect the recent major staffing changes and provide clarity for the team.

The GP team comprised of partners and salaried GPs but the practice was not hierarchical and actively encouraged teamwork. The recent staffing changes had resulted in wider pool of associates than under the previous staffing structure where GPs had been predominantly partners. It was the ethos of the practice that all GPs were encouraged to be actively involved in governance. Salaried GPs confirmed they felt consulted about practice changes. One partner told us the clinical team had pulled together amazingly to maintain the level and standard of service when a GP due to join the practice had withdrawn at very short notice. Another said the practice viewed the major changes experienced over the past few months positively as an opportunity to develop the team and best meet patient needs. Although the new team was in its infancy it functioned and communicated well despite the number of branches and variety of hours staff worked.

The partners held monthly meetings at which matters such as performance, quality and risks were discussed. Associate GPs regularly met separately as a group with the practice manager and one of the partners in attendance.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The clinical audit team carried out audits in relation to QOF criteria to review and monitor performance. We were told that QOF data was discussed at governance meetings and plans drawn to maintain or improve outcomes.

Leadership, openness and transparency

Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

There was an open culture within the practice. There was a regular programme of meetings for staff teams which included full staff events. There was a practice staff lunchtime gathering each week and a full staff meeting each alternate month. Staff confirmed they had opportunity and were happy to raise issues at team meetings.

A practice away day was scheduled for the day following our inspection. We saw there had been a number of staff events in relation to the merger for the purpose of disseminating information to keep the teams fully informed.

Staff consistently described their colleagues as approachable and supportive. It was clear individuals shared a mutual respect and appreciation of each others contribution to the practice team. We were told the practice was a good place to work and that everyone got on well helped each other. Buddy systems were in place to support associate GPs who had recently joined the team

Are services well-led?

Good

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

and each had a partner mentor. The registrar attached to the practice told us they benefitted from weekly tutorials with both their education and clinical supervisor GPs in addition to debrief sessions after each surgery.

Practice seeks and acts on feedback from users, public and staff

One of the partner GPs took the lead for the practice on patient engagement. Annual patient surveys were conducted through the Patient Participation Group. The last one had been completed in March 2014. Responses were received from 181 patients. Patients were asked to comment on matters such as ease of access to a telephone consultation with their GP, the ease with which they could get an appointment at the practice, the availability of information leaflets in the surgery and usefulness of the practice website. The surveys offered opportunity for respondents to make suggestions on how improvements to their care might be achieved. The practice analysed the results of the survey and produced a proposed action plan to address issues raised. This was shared with the Patient Participation Group for comment before being put into effect. For example, as a direct result of feedback received from patients the practice had moved their extended opening hours from a branch surgery on a Saturday to the main surgery on a Monday. There were also plans for a defibrillator to be made available at the branch surgery in Bolton-le-Sands.

A number of public consultation events had been held in relation to the merger. The practice manager reported that attendance had been high. The practice produced a newsletter which included information about the merger and a copy was posted on the website. There was a dedicated email address for members of the public to provide feedback on the proposals.

The practice had arranged a number of staff events regarding the merger. These had included a team building and planning day for staff from both practices in July 2014, and a full staff briefing in September 2014. One of the main messages to staff was to emphasise the practice's intention to value staff ideas and suggestions, and to encourage ownership of the merger. We saw that the agendas for such events had included discussion of future development, timescales, welcoming new starters, plans for social events and celebration of achievements. They also included information about aspects of employment law relevant to the staff in consequence of the merger.

Practice policies and procedures were available on the intranet which included Whistleblowing. Whistleblowing is defined as the disclosure by an employee of confidential information, which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace be it of the employer or a fellow employee. Staff confirmed they knew where to find policies if required.

Management lead through learning & improvement

Staff joining the practice were given a planned induction tailored to their role.

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. There were good development opportunities within the practice. For example, primary health care support workers had been trained to do simple dressings and flu vaccinations. There were plans for nurses to receive training in spirometry and family planning.

Internal staff training was shared amongst the GPs and we were told that agendas for a number of scheduled meetings within the practice regularly included elements of training. The Clinical Commissioning Group had funded a package of online training for staff and had supported plans for the practice to close for half a day periodically to enable staff to pursue this.

In addition to the regular clinical meetings there were plans to introduce a clinical discussion group to discuss complex cases. GPs were supported in their appraisal process by the availability of material from clinical meetings for development of their appraisal portfolios.