

Bentley Surgery

Quality Report

128 High Street
Bentley
Doncaster
South Yorkshire
DN5 0AT

Tel: 01302 87455

Website: www.bentleysurgery.co.uk

Date of inspection visit: 7 January 2015

Date of publication: 19/03/2015

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8
Outstanding practice	8

Detailed findings from this inspection

Our inspection team	9
Background to Bentley Surgery	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bentley Surgery on 07 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people and people experiencing poor mental health. The practice is rated as outstanding for people whose circumstances make them vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

- The practice was involved in the local CCG's enhanced safeguarding pilot and was one of only two practices carrying out assessments of Looked After Children.

Summary of findings

- The practice was piloting an Electronic Palliative Care Co-ordination Systems (EPaCCS) for the management of patients receiving end of life care.
- The practice had organised health checks for members of the public at a local community festival.
- The practice made special provisions for patients from traveller communities who were known to temporarily move out of the practice area from time to time.
- Transgender patients sought out the practice because of the open and accepting culture.

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?

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 patient care were regularly assessed. Performance was routinely monitored. There were systems to review risks to vulnerable children, young people and adults. Medicines, infection control and emergency procedures were managed effectively.

Good



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Clinical audit, clinical supervision and staff meetings were used to assess the performance. The practice had an effective system in place for completing clinical audit cycles. Staff had clearly defined roles in monitoring and improving outcomes for patients. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs, including piloting an Electronic Palliative Care Co-ordination Systems (EPaCCS) for the management of patients receiving end of life care.

Good



Are services caring?

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 was available to help patients understand the services available. Care planning templates were available for staff to use during consultations. Patients were also provided with their own copy of their care plan.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to

Good



Summary of findings

secure improvements to services. The needs of the practice population were understood. Systems were in place to ensure services were delivered in ways which addressed identified needs. Longer appointment times were available, for example for patients with complex needs or where they were supported by a carer. There were systems to identify patients with high usage of health care services and prioritise access so as to reduce the number of avoidable admissions to hospital. The practice had recognised the needs of different groups in the planning of its services. Equality and diversity training had been provided for the staff. The practice made special provisions for patients from traveller communities who were known to temporarily move out of the practice area from time to time. Transgender patients sought out the practice because of the staff's open and accepting culture. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

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

Good



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

The practice is rated as good for the care of older people. It was responsive to the needs of older people, and offered a named GP for those aged over 75 years. The practice offered proactive, personalised care and designed services to meet the needs of the older people in its population. This included home visits, longer appointments and end of life care.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients had annual reviews to check that their health and medication needs were being met. Staff worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

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. For example, children and young people who had a high number of A&E attendances. The practice was involved in the local CCG's enhanced safeguarding pilot and was one of only two local practices carrying out assessments of Looked After Children. Training records showed that all staff had received relevant role specific safeguarding training. The practice held monthly meetings with school nurses and health visitors. In response to a serious case review they had developed specific protocols, including a Children's Information Form to improve communications about vulnerable children.

Good



Working age people (including those recently retired and students)

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 and flexible. It was practice policy to offer a health check 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

Good



Summary of findings

Checks to all its patients aged 40 to 75 years. The practice had organised a health check event at a community festival and followed up patients who were identified as needing more detailed examinations.

People whose circumstances may make them vulnerable

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice worked with multi-disciplinary teams in the case management of vulnerable people. It advised vulnerable patients how to access various support groups and voluntary organisations. Staff 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. The practice carried out annual health checks for people with a learning disability and offered longer appointments. The practice was piloting an Electronic Palliative Care Co-ordination Systems (EPaCCS) for the management of patients receiving end of life care. There were special provisions for patients from traveller communities who were known to temporarily move out of the practice area from time to time. Transgender patients sought out the practice because of the practice's open and accepting culture.

Outstanding



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had annual assessments and physical health checks. Longer appointments and end of day appointments were available.

Good



Summary of findings

What people who use the service say

During our visit we spoke with three patients and eight members of the patient participation group (PPG). We also reviewed 24 completed CQC comment cards. Patients were very complimentary about the staff and the care and treatment they received. They said they could usually get an appointment when they wanted one. Patients described the staff as friendly and caring. They felt that they were treated with dignity and respect. Patients told us they were involved in decisions about their care and treatment, and were satisfied with the care and service they received. Only one patient expressed dissatisfaction with the response they received when contacting the practice.

We looked at the December 2014 results of national GP survey. We saw that 112 patients had responded to the survey and compared the responses to the average for other practices in the local Clinical Commissioning Group (CCG). Areas where the responses were better than the local CCG average included; ease of contacting the practice by telephone (18% higher), experience of making an appointment (17% higher) and patients who would recommend the surgery to someone new to the area (12% higher). The percentage of patients who expressed confidence in their GP (93%), usually having to wait 15 minutes or less to be seen (69%) and saying their last appointment was convenient (92%) was very similar or equal to the CCG averages.

Outstanding practice

- The practice was involved in the local CCG's enhanced safeguarding pilot and was one of only two practices carrying out assessments of Looked After Children.
- The practice was piloting an Electronic Palliative Care Co-ordination Systems (EPaCCS) for the management of patients receiving end of life care.
- The practice had organised health checks for members of the public at a local community festival.
- The practice made special provisions for patients from traveller communities who were known to temporarily move out of the practice area from time to time.
- Transgender patients sought out the practice because of the staff's open and accepting culture.

Bentley 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 and a second CQC inspector.

Background to Bentley Surgery

Bentley Surgery is located approximately two miles north of Doncaster. The practice provides primary medical care services for approximately 7200 patients under the terms of the national NHS General Medical Services contract. The practice catchment area, which includes villages local to the surgery, former mining communities and three traveller sites, is classed as within the group of 20% most deprived areas in England. Income deprivation indices affecting children (30%) and older people (28%) are significantly higher than the CCG (23% and 22%) and England (22% and 18%) averages. The age profile of the practice population is broadly similar to other GP practices in the Doncaster CCG area.

There are five GPs (two male and three female) at the practice. The GPs are supported by four practice nurses, three healthcare assistants and an experienced management and administrative team. In addition to their practice responsibilities the clinical staff have lead roles within the CCG for safeguarding, the McMillan cancer survivorship programme, end of life care and prescribing. They also support GP training and GP appraisal, clinical research and advise the Children's Clinical Network.

The practice reception is open from 8.00am until 6.00pm on Monday, Wednesday and Friday and from 7.30am until 6pm on a Tuesday and from 7.30am until 7.30pm on a

Thursday. The practice leaflet and web site include details of surgery and GP appointments times. GP appointments are available from 8.00am to 5.30pm each weekday, however, extended appointment times are available on Tuesday mornings and Thursday evenings. Routine and specialist clinics such as chronic disease, minor surgery, ante-natal and endometrial biopsy diagnostic testing are also available. Out of hours care is provided by Doncaster Emergency Out of Hours Service.

The CQC intelligent monitoring (December 2014) placed the practice in band 6. 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 6 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.

Bentley Surgery is registered to provide; diagnostic and screening procedures, family planning, maternity and midwifery services surgical procedures and the treatment of disease, disorder or injury from 128 High Street, Bentley, Doncaster, South Yorkshire, DN5 0AT.

Why we carried out this inspection

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

Detailed findings

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 January 2015. During our visit we spoke with GPs, nurses, the practice manager, deputy manager, reception and administrative staff and spoke with patients who used the service.

Are services safe?

Our findings

Safe track record

The practice showed a proactive approach to anticipating and managing risks to patients. A number of different sources of information, such as; medication reviews, complaints, clinical audits and patient safety alerts were used to identify risks and improve patient safety. There was a well-developed audit programme which included an audit of urgent (two week) referrals. We reviewed two clinical audit cycles which showed that there was a systematic approach to quality improvement and patient safety. Audit records, incident reports and minutes of meetings showed that the practice had managed safety consistently over time.

Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and follow up safety alerts. For example following receipt of a national alert about a diabetic testing pen the practice had identified all the relevant patients and provided information and advice about obtaining new testing pens. A GP then contacted the patients concerned to check that they had received the information and new testing pens.

Learning and improvement from safety incidents

There was an open culture in which all safety concerns raised by staff and patients were regarded as integral to learning and improvement. There were effective systems to report, review and learn from safety incidents, concerns and complaints. There were records of eight complaints and 18 significant events during 2014. We looked at summaries for nine significant events. They were categorised as either clinical or administrative and included learning points or improvement actions. We looked at one significant event in detail and saw that the practice had identified concerns about the routine blood testing of patients prescribed certain oral anticoagulants. As a result of the audit the practice had stopped carrying out this test at the practice

Discussion of significant events was a regular item on the practice meeting agenda. There was evidence that the practice had learnt from significant events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise issues for discussion and they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

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

The practice had appointed a named GP to act as the lead for safeguarding vulnerable adults and children. They had undergone relevant training, including level 3 children's safeguarding, to enable them to fulfil this role. All staff we spoke with were aware who the practice safeguarding lead was and who to speak within the practice if they had a safeguarding concern. The practice was also involved in the local CCG's enhanced safeguarding pilot and was one of only two local practices carrying out assessments of Looked After Children. One of the GPs was the responsible for convening an annual safeguarding review meeting for all GPs in the Clinical Commissioning Group (CCG). The practice held monthly meetings with school nurses and health visitors to share information and safeguarding concerns. In response to a serious case review they had developed specific protocols, including a Children's Information Form to improve communications about vulnerable children.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

Information advising patients of the availability of chaperones was displayed in the reception area and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff and health care assistants had been trained to act as chaperones. We saw that patient notes included details of the presence of a chaperone.

Are services safe?

Medicines management

There were effective procedures to ensure that medicines were handled and stored appropriately at all times. The procedures included recording the time of delivery and transfer of vaccines to medicine refrigerators to ensure there had been no break in the cold chain. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Procedures were in place to check medicines were within their expiry date and suitable for use. Daily temperature records and weekly contents checks were maintained for each refrigerator. Staff were aware of the action to take in the event of a potential failure of the cold chain. Notices detailing expiry dates were prominently displayed on each refrigerator. Expired and unwanted medicines were disposed of in line with waste regulations.

Cleanliness and infection control

The practice premises were visibly clean and tidy. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control. One of the practice nurses was designated as the lead member of staff for managing and monitoring standards of cleanliness and infection control. They had undertaken appropriate training to enable them to provide advice on infection control requirements and carry out staff training.

Daily, weekly and monthly cleaning schedules were in use and cleaning records were kept. Coloured coded cleaning equipment was in use to reduce the risk of cross contamination. Cleaning equipment and supplies were kept in a locked cupboard. Some of the shelving was in poor condition and was not amenable to thorough cleaning and decontamination. This increased the risk of contamination of stored cleaning equipment.

Hand washing signage and materials were available. There were facilities for the segregation of clinical and non-clinical waste, including sharps. Staff had access to personal protective clothing (gloves and aprons) and were aware of procedures for the safe handling of patient samples. Staff had received induction training about infection control specific to their role. They were also able to refer to the practice's infection control policy and supporting procedures for guidance.

There were regular checks and full audits of the standards of cleanliness and infection control. The most recent audit

had been completed in December 2014. Minor improvement actions had been identified and addressed. We noted that a dressing trolley and a gas cylinder in one of the treatment rooms were in poor condition and had signs of corrosion. This reduces the effectiveness of routine cleaning and disinfection and the practice should consider removing or replacing these items.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water) and no risk assessments of water outlets had been undertaken. The practice should review these arrangements and obtain assurance as to the safety of the water supply.

Equipment

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

Staffing and recruitment

The practice recruitment policy set out the standards to be followed when recruiting clinical and non-clinical staff. Staff 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).

Staff told us that there were always sufficient staff on duty to meet patients' needs. There were monthly staff meetings to review workload and staffing capacity. Staffing rotas were agreed well in advance. A number of the administrative staff worked part-time and were willing to work flexibly and cover holidays and absences at short notice. The practice did not use locum staff and GP and nurse absences were managed within the existing clinical team.

Monitoring safety and responding to risk

Are services safe?

Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned and managed effectively. Plans were in place for emergencies and major situations. All staff understood their role and plans were tested and reviewed.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included planned checks of the building, working environment, fire safety, infection control and emergencies. Upgrading of floor surfaces with non-slip coverings had taken place to reduce the risk of frail and/or elderly patients falling. A chair lift had been installed to enable patient access to the first floor consulting and treatment rooms. Harmful or hazardous items such as cleaning chemicals and sharps, were stored securely and out of reach of children. The practice health and safety policy was accessible by all the staff. Health and safety information was displayed and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

The practice had planned staff availability to ensure appointments were available from 8.00am to 5.30pm each weekday and extended appointment times on Tuesday mornings and Thursday evenings. Demand for appointments was continually monitored and staff capacity increased whenever required to ensure patients were able to see a GP or nurse without . Longer appointments and end of day appointments were available for patients experiencing poor mental health.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, the practice was participating in the Transforming Primary Care Project for patients at high risk of hospital admission. Risk tools had been introduced to support the management of these patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that the staff had received training in basic life support. They could describe the actions to take in the event of an emergency, for example a patient suffering a fall or loss of consciousness. 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). Emergency medicines were available in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. Practice records confirmed the emergency equipment and medicines were checked regularly.

The practice had carried out annual fire risk assessments. Designated staff on each floor had been appointed as fire safety officers. Records showed that staff were up to date with fire training and that they practised fire evacuation procedures. A business continuity plan was in place to deal with emergencies that could have an adverse impact on the daily operation of the practice. Each risk was rated and actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the heating company to contact if the heating system failed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical protocols were available for staff to use when providing care and treatment. Updates to current best practice guidance were monitored and updated by one of the practice nurses. Individual members of the clinical team had areas of speciality. For example; paediatric care, chronic obstructive pulmonary disease or asthma. We saw minutes of practice meetings where new guidelines and the implications for the practice's performance and patients were discussed.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The practice had a relatively high proportion of patients from traveller communities and offered flexibility with registration, appointments and review meetings. We were also told that transgender patients sought out the practice because of the staff's open and accepting culture.

Management, monitoring and improving outcomes for people

Staff had clearly defined roles in monitoring and improving outcomes for patients. These included identifying patients for recall, follow-up of missed appointments, repeat prescriptions and monitoring performance data. Staff were trained in dual roles to ensure that cover was available in the event of an absence.

All patients aged over 75 years had a named GP. They received regular medication reviews and assessments of compliance with prescribed medicines. Home visits were undertaken where appropriate and there was flexibility in appointment times to support the involvement of family members or carers. Patients reaching 65 years were invited to attend for immunisation against pneumococcal and shingles infections.

The practice nursing staff had undergone specific training in the management of long term conditions. Patients were able to have their routine health checks completed in a single appointment, including assessments for depression. Patients experiencing poor mental health had annual assessments and physical health checks.

The practice planned and delivered services for families, children and young people in conjunction with community midwives, health visitors, school nursing teams and the local children's centre (Surestart). Eight week mother and baby checks were carried out at a single visit. Mothers who did not attend their appointments with their babies or missed childhood immunisation appointments were followed up. Additional nasal influenza immunisation sessions had also been arranged at local schools to increase the level of coverage against infection.

Disease registers were maintained for specific patient groups, for example patients with diabetes or patients with a learning disability. Quarterly multidisciplinary meetings were held to discuss the care and support needs of patients on the palliative care register. We noted that the practice palliative care prevalence had increased from 0.44% in 2012-13 to 0.57% in 2013-14, a rise of 31%. The practice 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 compared favourably compared to other services in the area. For example, seasonal influenza vaccination of at risk of patients. In the case of non-steroidal anti-inflammatory drugs (NSAIDs) the practice had been effective in changing prescribing practice in response to national safety warnings about the risks of some NSAIDs. Practice prescribing of safer alternatives was 93%, the third highest in the CCG.

Information collected for the Quality and Outcome Framework (QOF) and performance against national screening programmes was also used to monitor outcomes for patients. In 2013-14 the practice achieved 100% in 18 of the 20 QOF clinical domain indicators and was above the CCG and England average achievement for all 20.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for completing clinical audit cycles. We were provided with summaries of seven clinical audits that had been completed in 2014. Following each audit, actions had been identified and changes to treatment or care were made. Where appropriate a repeat audit had been scheduled to ensure outcomes for patients had improved. For example, one of the GPs had been accredited to undertake excisions of low grade Basal Cell Carcinomas (BCC). The aim of the audit was to identify the number of

Are services effective?

(for example, treatment is effective)

incomplete excisions compared to the target performance criteria of less than 7%. The first audit, in 2013, demonstrated that none of the six patients undergoing treatment were found to have incomplete excisions. A repeat of the audit in 2014 involving a further four patients again showed that of those with confirmed BCC the number of incomplete excisions was zero. The results of the audits were shared with other GPs, local commissioners and at a dermatology MDT meeting.

An electronic prescribing system (EPS) was used to audit and authorise repeat prescriptions for patients with long term conditions. The system was also used to highlight any under or over usage of medicines. We saw records which confirmed GPs had carried out appropriate checks before authorising medicines. For example, patients receiving medicines under a shared care protocol with a hospital consultant. The practice clinical system was used to alert staff to patients requiring medication reviews. Where appropriate medication reviews included checks on patient compliance with dosage instructions and a discussion of the side effects of medication. Regular audits were carried out of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Practice data was also compared with data from other practices to identify potential anomalies.

Effective staffing

An employee handbook was provided to all members of staff. Effective recruitment policies and procedures were in place. Specific induction programmes were available for new clinical and administrative staff. procedures were also in place to manage poor performance. Practice staffing included medical, 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. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

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 equality and diversity, information security and improving the patient experience.

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 and cervical cytology. Those with extended roles such as seeing patients with long-term conditions such as asthma or diabetes had received appropriate training to fulfil these roles.

Working with colleagues and other services

All staff at the practice were involved in the planning and delivery of services to patients. For example, planning and organising annual influenza vaccination clinics, which also involved consulting members of the practice's patient participation group (PPG). The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. Blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service were received both electronically and by post. There were clear systems to ensure results and patient correspondence were directed to the relevant clinician or reassigned to an authorised member of staff in their absence. The GP reviewing 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.

The practice held multidisciplinary team meetings to discuss the needs of complex patients. For example the practice was piloting an Electronic Palliative Care Co-ordination Systems (EPaCCS) for the management of patients receiving end of life care. The purpose of EPaCCS is to support the co-ordination of care so that people's choices about where they die, and the nature of the care and support they receive, will be respected and achieved wherever possible. In addition to communicating key medical information to healthcare professionals involved in patient care, EPaCCS supports conversations about end of life care wishes. We were shown anonymised summary care records detailing the diagnosis, related problems, carer contact information and a handover record for the out of hours team. The record included checks that advanced wishes had been discussed and anticipatory medicines were available.

Are services effective?

(for example, treatment is effective)

Information sharing

The practice had systems to provide staff with the information they needed to carry out their roles effectively. Staff used an electronic patient record to coordinate, document and manage patients' care. This included alerts to identify outstanding clinical tests or vulnerable patients for example at risk children. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system also allowed direct communication with secondary care (hospital) departments, such as haematology and ENT. 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. Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Consent to care and treatment

Staff understood the relevant consent and decision making requirements of the Mental Capacity Act 2005, the Children Acts 1989 and 2004. The practice consent policy was accessible by all the staff. Examples of completed consent forms were available. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice had discussed the needs of the practice population with the Public Health team from the local authority. They had also worked with the CCG to discuss the implications and share information about the needs identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check 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 to 75 years. The practice had organised a health check event at a local community festival. One patient told us they had taken advantage of a health check and had been found to have a high blood pressure result. They had been sent to the practice for a full health screen and were later diagnosed with diabetes.

The practice had systems to identify patients who needed additional support. For example, the practice kept a register of all patients with a learning disability and offered an annual physical health check. Practice records showed all had received a check up in the last 12 months. Systems were in place to refer or signpost patients to other sources of support, for example smoking cessations or healthy living clinics. The practice was participating in the local social prescribing scheme. Leaflets were available informing patients about the service, which provided a single point of contact for range of social problems such as assistance with housing, healthy lifestyles, managing money and emotional well-being. There were also options for signposting to community activities such as a local walking group.

The practice's performance for cervical smear uptake for 2013-14 was 81%, which was similar to other practices in the CCG area. There was a policy to follow up patients who did not attend for cervical smears and the practice achievement rate at the time of our visit was 89%. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was similar to other practices in the CCG and there was a policy for following up non-attenders.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey (December 2014) and a survey of 150 patients undertaken by the practice's patient participation group (PPG) in February 2014. The results indicated that patients were satisfied with the service they received from the practice. For example, data from the national GP patient survey showed the practice was rated above the CCG average for patients who would recommend the practice to others. Similarly satisfaction with telephone access and opening hours was above the CCG average.

Patients completed CQC comment cards to tell us what they thought about the practice. Patients were very complimentary about the staff and the care and treatment they received. They told us they were pleased with the service they received from the doctors, nurses and reception staff. Only one patient was unhappy with the response they received when contacting the practice. We also spoke with two patients and eight members of the patient participation group (PPG) on the day of our inspection. They were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that consultations and treatments were carried out in the privacy of a consulting room. Privacy 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 consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

Patients were supported to understand and be involved in their own care. Care planning templates were available for staff to use during consultations. Where appropriate patients were also provided with their own copy of their care plan.

The staff were able to arrange for an interpreter to support patients who had difficulty communicating in English. A range of patient health and support information leaflets were available in the reception area. Information was also available in other languages if requested.

The national GP patient survey indicated that 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, 84% of respondents said the GP involved them in care decisions, 92% felt the GP was good at explaining treatment and results and 93% had confidence and trust in the last GP they saw or spoke to.

Patients who had completed CQC comment cards indicated that their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also 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/carer support to cope emotionally with care and treatment

The practice had a well-developed palliative care and bereavement support service, which included a register of patients receiving end of life care. Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The services reflected the needs of the patients and offered flexibility and choice. For example staff ensured sufficient appointments were available at times convenient to patients. Longer appointment times were available, for example for patients with complex needs or where they were supported by a carer.

Registers were maintained of patients with long term conditions, patients who were carers or patients who had a carer. There were systems to identify patients with high usage of health care services and prioritise access so as to reduce the number of avoidable admissions to hospital.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, piloting lunch time appointments one day a week and installing a new audio system in the waiting room to improve audibility of patient announcements.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Equality and diversity training had been provided for the staff. The practice made special provisions to meet the needs of its patients. These included; slip resistant flooring, a stair lift and flexibility with registration and appointments for traveller communities which were known to temporarily move out of the practice area from time to time. There was access to online and telephone translation services and one of the reception staff was trained in the use of British sign language. We were also told that transgender patients sought out the practice because of the practice's open and accepting culture. Patients with multiple long term conditions had a single health check so as to avoid the need for multiple appointments. Patients who were unable to attend the surgery had their annual health checks carried out during home visits.

Access to the service

The practice reception was open from 8.00am until 6.00pm each weekday. The practice leaflet and web site included details of surgery and GP appointments times. GP appointments were available from 8.00am to 5.30pm each weekday. Extended appointment times were also available on Tuesday mornings from 7.30am and Thursday evenings until 7.30pm. At 1.00pm on the day of our visit we saw that the next available urgent appointment was 1.30pm. However, when all the scheduled urgent appointment times had been allocated additional requests would be triaged and patients would be seen if needed. The next available routine appointment was at 4.10pm, however the practice did tell us this was unusual and (non-urgent) routine appointments were more typically within four to five days.

Patients were generally satisfied with the appointments system. The results of the most recent national GP patient survey indicated that 91% of the patients who responded described their experience of making an appointment as good. A further 92% said their last appointment was convenient. Comments received from patients showed that patients in urgent need of treatment had been able to speak to a GP and if necessary make appointments on the same day of contacting the practice. We heard examples of how the staff had prioritised urgent appointments for young children, provided urgent care for a relative of a patient visiting from overseas and provided emotional and clinical support following a traumatic birth.

Listening and learning from concerns and complaints

There were effective systems to manage complaints. We saw that information about the complaints procedure was available in the patient waiting areas. Named staff were identified as leads for complaints handling. They had received training in NHS complaints management. We reviewed summaries of all complaints received in 2014. They included records of verbal and written complaints, the nature of the complaint and a summary of the agreed actions. For example; offers to meet with a member of staff, changes to practice procedures and providing written explanations and apologies to patients. The practice reviewed complaints at practice meetings and also annually to detect themes or trends.

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 aim was to provide high quality, safe, caring and effective primary health care. Staff described the practice as safe, caring and compassionate. These values were also consistent with patients' experiences of the service. Staff followed a code of conduct and placed patient care as their priority. Senior staff monitored standards by listening to feedback, and observing how staff interacted with one another and patients. Staff felt there was good team work and they were well supported.

The practice were aware of the challenges of maintaining and developing the service. Staff had attended a development day and reviewed their strengths and weaknesses. They had asked staff to submit proposals for improvements to the premises and begun development of a long term business plan.

Governance arrangements

The practice had appropriate policies and procedures in place to govern activity. There was a clear leadership and organisational structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. All staff had been issued with job descriptions and they were clear about their own roles and responsibilities. They told us they felt valued and knew who to go to in the practice with any problems.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above the CCG and England averages. The practice held monthly regular clinical, nominated leads and staff meetings to discuss the performance and management of the practice. We looked at minutes of meetings held between September 2014 and January 2015 and found that significant events, complaints, performance and clinical practice had been discussed.

Leadership, openness and transparency

The practice manager and deputy manager were responsible for human resource policies and procedures. For example, recruitment, induction, sickness absence and whistleblowing procedures were in place to support staff. Senior staff were visible and approachable. The culture within the practice encouraged openness and honesty. Staff felt able to raise concerns and felt they would be listened to. Staff well-being was taken seriously and managers ensured no one worked excessive hours.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, a suggestion box, comments posted on NHS Choices and complaints. The practice also had an active patient participation group (PPG). The PPG had been established for approximately two years and had 8 active members who attended meetings on a regular basis. We were told the group was trying to encourage more young patients (16-18 year olds) and carers to become involved.

The PPG met with practice staff, including GPs, four times a year. They were encouraged to raise items for discussion and had made suggestions which the practice had followed up. We looked at the results of a survey carried out by the PPG in 2014. We saw as a result of patient comments the practice had carried out redecoration of the waiting area and improved the system for booking follow-up appointments to reduce queues at the reception desk. The minutes of the most recent meeting (December 2014) were available. We noted the group had discussed comments and anonymised complaints received by the practice, electronic prescribing and priorities for future action.

Management lead through learning and improvement

Staff were supported to maintain their clinical professional development through training and mentoring. Regular appraisals took place which included reviews of training and development needs. Staff training days were held on fourteen afternoons per year. Staff undertook lead roles within the CCG and organised CCG wide training events. The practice was a GP training practice, carried out GP appraisals and participated in clinical research programmes.