Dr Douglas Moederle-Lumb (Peasholm Surgery)

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 3 November 2014. Peasholm Surgery provides primary medical services (a PMS contract) to approximately 8,000 patients in Scarborough and surrounding areas.

Overall, we rated this practice as good.

Our key findings were as follows:

- The practice provided a good standard of care, considered in accordance with current best practice guidelines.
- Patients told us they were treated with dignity and respect, and were well informed around practice news.
- Patients told us they received a good service and were usually able to get an appointment without too much difficulty.
- The practice worked well with other providers, especially around end of life care and complex conditions.
- Staff told us they felt confident, well-trained, and supported by management.
- The practice had systems and processes in place to provide a safe service.
- The building was clean, and the risk of infection was kept to a minimum by systems such as the use of disposable sterile instruments.
- The practice offered a variety of pre-booked appointments and extended opening hours.
- Incidents and complaints were appropriately investigated and responded to, and learning was shared across the practice.

We saw some areas of outstanding practice including:

- The practice had earlier in the year merged with another in the local area, which meant the practice doubled in size. Staff and patients alike reported they were kept well informed and consulted throughout this process, and that services had been maintained or improved, such as providing better access to GPs.
- Patients we spoke with felt informed and involved in the practice and were aware of the practice's plans for the future, such as a move to new premises.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their roles and responsibilities in raising concerns, and reporting incidents. Lessons were learned from incidents and these were communicated throughout the practice. The practice had assessed risks to those using or working at the practice and kept these under review. There were sufficient emergency procedures in place to keep people safe. There were processes around use of equipment, infection control and medicines management for staff to follow which kept people safe. There were sufficient numbers of staff with an appropriate skill mix to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Quality data showed patient outcomes were improving over time. NICE guidance was referred to routinely, and people's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles. Clinical staff undertook audits of care, and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. The majority of patients gave us positive feedback where they stated that they were treated with compassion, dignity and respect, and were involved in decisions about their treatment and care. The practice was accessible. In patient surveys, the practice scored highly for satisfaction with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated extended opening hours to minimise disruption following a merger with another practice, and patients reported the appointments system worked well for them. The practice had a good overview of the needs of their local population, and had actively engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were required. The practice building sometimes meant staff were not able to be utilised fully due to a lack of available rooms, however the provider was actively seeking new premises. Information was provided to help people make a complaint, and there was evidence of shared learning from complaints with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure, with the practice led by the provider and practice manager. Staff felt supported by management and reported there was an open culture in which they were encouraged to give their views. There were systems in place to monitor quality and identify risk. The practice had an active and engaged Patient Participation Group (PPG), and was able to evidence where changes had been made as a result of PPG and staff feedback. The practice staff had responded positively to change following a merger, and remained engaged with a strong focus on customer service and teamwork.

Summary of findings

What people who use the service say

In the most recent NHS England GP patient survey, 89.9% of people described their overall experience as good or very good, with 87.6% saying the GP was good or very good at treating them with care and concern, both these figures being above the national average.

In the latest practice survey from September 2014, 92% of patients said the GP listened to them either very well or extremely well, 89% of patients said their medical condition was explained well to them, and 92% of patients described reception staff as very or extremely friendly.

We spoke to a member of the Patient Participation Group (PPG) prior to the inspection, and spoke to three patients during the inspection. The PPG member told us they felt involved and empowered by the practice, and that their views and feedback were taken into account in helping to shape services.

We also collected 22 CQC comment cards which were sent to the practice before the inspection for patients to fill in. The vast majority of comments received were positive, with people praising all the staff as caring, professional and helpful, and being happy with the care they had received. Patients also commented that the building and facilities were clean. Patients told us they felt involved in their care and were treated with empathy and compassion. A minority of people commented that sometimes it was difficult to access their GP of choice, but said on the whole the appointments system worked well.

Outstanding practice

- The practice had earlier in the year merged with another in the local area, which meant the practice doubled in size. Staff and patients alike reported they were kept well informed and consulted throughout this process, and that services had been maintained or improved, such as providing better access to GPs.
- Patients we spoke with felt informed and involved in the practice and were aware of the practice's plans for the future, such as a move to new premises.

Dr Douglas Moederle-Lumb (Peasholm 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 specialist advisor and a Practice Manager specialist advisor.

Background to Dr Douglas Moederle-Lumb (Peasholm Surgery)

Peasholm Surgery, Tennyson Avenue, Scarborough provides primary medical services (PMS) to just over 8,000 patients in and around Scarborough. The practice was previously of around 4,000 patients. In January 2014 a merger with another local practice meant the patient list doubled in size. Practice staff and GP's had their employment transferred over, forming one larger practice at Peasholm.

There are seven GPs, Dr Moederle-Lumb, who owns the practice, and six salaried GPs. There is a mix of male and female GPs. There are three nurse practitioners, three practice nurses, and two healthcare assistants. They are supported by the practice manager, and a team of management, reception and administrative staff.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury. The practice population aged less than 18 years is lower than the England average, with higher levels of those aged 50-69. The practice is in the Scarborough and Ryedale Clinical Commissioning Group (CCG) area, which has higher levels of deprivation than the England average, with lower life expectancies.

Surgeries are provided from 8am until 8pm five days a week. The practice had opted out of providing out of hours services, therefore outside of these times patients can access GP services via the 111 service.

Why we carried out this inspection

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

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?

Detailed findings

- 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 our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also spoke with a member of the Patient Participation Group.

We carried out an announced inspection on 03 November 2014.

We reviewed all areas of Peasholm Surgery including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, registered manager, GP's, nurses and a nurse practitioner, healthcare assistants, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety including reported incidents, national patient safety alerts, and complaints. Some of the incidents and complaints were then investigated as significant events. Prior to inspection the practice provided us with a summary of significant events from the preceding year. These had been reviewed and disseminated to staff in the practice and learning points had been discussed.

The records showed that staff reported incidents, including their own errors. Staff we spoke with were aware of the incident policy and how to access this, and felt encouraged to report incidents. Incidents were discussed weekly at practice meetings, with outcomes and actions then analysed at the next meeting. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development.

Information from the quality and outcomes framework (QOF) from 2012-13, a national performance measurement tool, showed that the provider was appropriately identifying and reporting significant events.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. Staff were able to provide examples of recent alerts they had received and how they had actioned these. From our discussions we found that GPs and other clinical staff were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

The practice worked with the Clinical Commissioning Group (CCG) in reporting any incidents of poor performance and missed follow up , such as a late referral. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. For example instances of late referral were audited for patient harm, to identify corrective actions, and what could be done to prevent the situation in the future.

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed, and the information then shared across the practice as learning points at weekly practice meetings. Sometimes feedback was given to a staff member individually. What changes had occurred from previous incidents were also followed up. Staff members said they were encouraged to report incidents and felt confident doing so. Staff were able to describe the process of reporting incidents initially to the practice manager, and confirmed these were the discussed with learning points to relevant staff at team meetings.

Staff told us, and we saw from meeting minutes, that feedback on learning from incidents was disseminated through practice meetings, and the provider was looking at ways in which they could improve on incident forms how outcomes were documented and evidenced, as they did not always formally record actions taken and by whom in detail.

We could see from a summary of significant events and complaints that in each case the practice had communicated with people to offer a full explanation and apology, and told what actions would be taken as a result.

National patient safety alerts were disseminated by email or via the practice's computer system to staff, and staff were able to give recent examples of alerts relevant to them and how they had actioned them.

Reliable safety systems and processes including safeguarding

The practice had up to date safeguarding policies and procedures in place, for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff knew how to access these. The practice had a named GP safeguarding lead for adults and a nurse practitioner lead for children, who staff were able to identify.

Staff had access to contact details for Local Authority safeguarding teams. They were able to describe types of abuse and how to report these. Staff were able to describe scenarios in which they had acted appropriately, and worked with safeguarding teams and other agencies such as social services. Staff had received an appropriate level of safeguarding training according to their role.

The practice had a register for vulnerable children and also discussed any cases at weekly practice meetings where there was potential risk or where people may become vulnerable. The practice worked with health visitors to share information and create action plans. The computerised patient records were used to enter codes to flag up issues where a patient may be vulnerable or require

extra support, for instance if they were a carer. The practice had systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

The practice had chaperone guidelines, details of which were in the practice leaflet, although this service was not advertised in reception. Some staff members had been given specialist chaperone training.

Patient records were kept on an electronic system which collated all communications about the patient, including scanned and email communications. Administrative staff had daily allocated tasks to ensure all information was entered onto the system so the most up to date information was available to staff. Staff were able to describe procedures for confidentiality to ensure records were stored or destroyed securely.

Some older paper records were kept in a locked outbuilding. These were stored in lockable cupboards, although it had not been common practice to lock the cupboards. The practice manager agreed to alter procedures to lock these and help ensure the safety of patient records.

Medicines Management

Medicines stored in the practice were kept securely and could only be accessed by authorised staff. We saw evidence that the doctors bags and emergency medicines were regularly checked to ensure that the contents were intact and in date.

We checked medicines stored in the fridges and found these were stored appropriately. Checks took place to make sure refrigerated medicines were kept at the correct temperature, and these checks were audited regularly. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Prescriptions were stored securely, and there was a system in place for GP's to double check repeat prescriptions before they were generated.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent alert and what action had been taken. This ensured staff were aware of any changes and patients received the best treatment for their condition.

GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. Medication reviews were linked in to chronic disease management reviews so patients could have their medicines looked at as part of a wider review of their condition. There was a recall system in place to ensure patients were given an appropriately timed medicine review before repeat prescriptions were issued.

Specific protocols had been developed around hypnotic and antibiotic prescribing in line with best practice guidance. Levels of prescribing and repeat prescribing were regularly audited, and if necessary discussed at internal GP appraisals. The practice had a medicines manager lead. Prescribing and medication policies had been developed with input from the CCG pharmaceutical advisers and were regularly reviewed.

Cleanliness & Infection Control

We observed all areas of the practice to be clean, tidy and well maintained. We saw there were detailed cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness.

The practice had infection prevention and control (IPC), waste disposal and legionella testing policies, and these were reviewed and updated regularly. Regular infection control audits were carried out of both the building and all equipment.

There was an identified IPC lead who staff were able to name. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas, and new recruits were given training during their first four weeks in employment. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice, including equipment were in place. Public toilets were observed to be clean and have supplies of hot water, soap, paper towels and hand sanitizer.

Good

Are services safe?

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were for single use. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment such as blood pressure monitors used in the practice were clean.

We saw evidence that staff had their immunisation status for Hepatitis B checked, which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Equipment

There were procedures in place to ensure that equipment was checked, calibrated and functioning correctly. Staff were trained and knowledgeable in the use of equipment for their daily jobs, and were able to describe how the equipment checking rota worked and what their responsibilities were each day.

Items of medical equipment were on service maintenance contracts where necessary to ensure their speedy repair or replacement. Equipment such as blood pressure monitors and scales were calibrated by an external company on a regular basis and records kept of this.

Contracts were in place for annual checks of equipment such as fire extinguishers, fire alarms and panic alarms. Portable appliance testing for electrical equipment was carried out to ensure it was safe to use. Review dates for these were overseen by the practice manager. Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staffing & Recruitment

The practice had merged with another local practice in January 2014, meaning some staff started new employment at Peasholm Surgery under transfer of employment regulations (TUPE). Staff had their skills and training mapped so they could be placed within the new organisation. Staff reported they felt they worked well together as a team.

Patients told us they had been worried that services would suffer as a result of the merger when the old practice closed, but they were now reassured that they could still access appointments and clinics as required, and there were sufficient staff to deal with the large numbers of new patients.

There were arrangements in place for members of staff, including GP's, nursing and administrative staff to cover each other's leave. Rotas were planned to ensure sufficient staff were on duty, and arrangements in place so administrative staff could help out in reception during busy periods. Staff told us about the arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs.

The provider recruitment policy was up-to-date. We looked at a sample of recruitment files for doctors, administrative staff and nurses. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service, for instance proof of identification references, qualifications, and criminal records checks by the Disclosure and Barring Service (DBS).

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks of the building, environment, equipment, and medicines management. Risk assessments were undertaken and measures put in place so patients, staff and visitors were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk. Health and safety was a standing agenda item on all practice meetings, and we saw from minutes that health and safety risks were discussed, or information disseminated.

Patients with a change in their condition or new diagnosis were discussed each week at practice clinical meetings, which allowed clinicians to monitor treatment and adjust it to respond to changing risks. The practice used a risk stratification tool to identify vulnerable patients. There

were emergency procedures for patients with a sudden deterioration in their condition. Information on such patients was made available to out of hours providers so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training. Staff who would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experienced a cardiac arrest. Staff could describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose. Staff knew the location of emergency equipment.

There was no automated option on the telephone answer message which enabled people to get straight through if their call was an emergency, or to direct people to call an ambulance. This meant if the lines were engaged the practice may not know that an urgent call was on hold.

The practice had a major incident policy which covered scenarios such as loss of the computer or telephone system, fire, flood, and large scale staff sickness. This included contact numbers for outside agencies and service engineers. These were reviewed regularly.

Regular fire alarm checks and fire evacuation drills took place. Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location. Processes were in place to check emergency medicines were within their expiry date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and demonstrated how these were disseminated to the relevant people via email. Staff used these to keep up to date with best practice and identify areas for clinical audit.

Treatment was considered in line with evidence based best practice, and we saw minutes of clinical staff meetings where new guidelines and protocols were discussed. The practice had developed a number of treatment templates on the computerised patient management system, for example for a specific long term condition such as diabetes. This assisted staff in providing care to patients using up to date guidance.

All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge, and once a month GP's from the practice attended a protocol development and clinical policies meeting.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. The practice had spent some time validating patient data from transferred patients following the merger, and were able to demonstrate patients were having their conditions proactively diagnosed and treated, for instance there had been an increase in the diagnosis of patients with chronic obstructive pulmonary disease (COPD), which in turn ensured that patients were placed on the correct care pathway and recalled at appropriate intervals for checks on their condition.

Practice nurses and nurse practitioners told us they managed specialist clinical areas such as diabetes, heart disease and asthma, in partnership with GP's. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates, and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness.

Patients with long term conditions or multiple conditions were having regular health checks, and were being referred to other services or discussed at multi-disciplinary meetings when required. Feedback from patients confirmed they were referred to other services or hospital when required. All GP's we spoke with used national standards for referral, two week referrals for patients with suspected cancer were done immediately and other routine referrals were done within seven days. All locum referrals were audited by the provider.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. QOF is a national performance measurement tool. The practice had worked closely with NHS England after the merger as the influx of new patients had a short term impact on performance information. However latest QOF submissions showed many patient outcomes steadily improving over time, in areas such as cancer review and long term conditions such as asthma.

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included prescribing of certain medication to help with weight loss, and management of patients on warfarin therapy. While the audits identified issues and contained some points for actions, not all audits seen included a date for re-audit so the practice would not be able to identify if any changes had led to improvements in care.

The team was making use of clinical audits tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. We saw minutes of meetings where clinical complaints were discussed and

Good

Are services effective?

(for example, treatment is effective)

the outcomes and practice analysed to see whether they could have been improved. Action points were documented, for example contacting patients to discuss a review of their medication.

The practice participated in external CCG audits in areas such as COPD patient outcomes and prescribing levels of certain medicines such as hypnotics and antibiotics, and were able to demonstrate that their own prescribing in these areas was at or below the CCG average. The practice was actively monitoring this and sourcing specialist additional training to further lower antibiotic prescribing.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. Clinical staff also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued, and when people needed to attend for routine checks related to their long term condition.

Effective staffing

The practice manager oversaw all training and provided us with a complete record from the last three years. Staff were sent reminders when essential training was due. We saw evidence that all GP's had undertaken annual external appraisals and had a date for revalidation, an assessment to ensure they remain fit to practice. The provider also carried out internal appraisals of GP's.

The practice had a training policy which stated all staff would have a training needs assessment on an annual basis, and described how staff could access additional training, for instance by arranging protected learning time. Staff confirmed they had learning needs identified and were able to give examples of extra training they had accessed, and a number of staff were working towards additional qualifications, such as vocational qualifications in clinical healthcare support.

The recruitment policy of the practice showed that relevant checks were made on qualifications and professional registration as part of the process. New staff we spoke with confirmed they had an induction which they described as thorough and useful, and which covered areas such as the premises and health and safety, in addition to further role specific training. We saw that the mandatory training for all staff included fire awareness, information governance, safeguarding and infection control.

We saw from records that new staff were given a one month and a three month review, where employees could give feedback, received feedback, and ongoing training needs were assessed. Thereafter they were scheduled for annual appraisal. All the records we looked at showed that staff were up to date with their appraisals. Continuing Professional Development for nurses was monitored as part of the appraisals process.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support. They gave examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure, although some staff did say it could be difficult to get time with the clinical lead GP for their area.

Nursing staff held regular clinical supervision and discussion meetings, where a GP also attended. Staff said they felt confident in raising concerns or issues.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff, and we saw where members of staff had been supported and adjustments made to their role.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. We found regular meetings were held to identify and discuss the needs of those requiring palliative care, which other health professionals such as Macmillan nurses attended. We saw where health visitors and social services had attended meetings to discuss safeguarding issues, and the practice held a rolling programme of meetings to assess patients who had unplanned admissions to hospital.

The practice had worked collaboratively with another in the local area, and now shared two members of nursing staff as care co-ordinators. A cohort of patients had been identified, and the care co-ordinators were engaged in producing care plans for those over the age of 75 and people whose circumstances may make them vulnerable, with the objective to avoid unplanned admissions to hospital. As part of a year long project the staff would make closer links with care homes in the area and A&E

Good

Are services effective?

(for example, treatment is effective)

consultants, although this was in the early stages so no evaluation was as yet available. The practice was also engaged in a pilot to integrate their nursing team with community nurses.

The practice had worked closely with the CCG and patients from both practices before and during the merger period, and some patients told us how they had attended an open evening where they were informed of changes. The practice was working with the CCG to agree a plan for federation of some practices in the area, this tied in with the provider's long term aim to move to newer, larger premises.

Health monitoring of patients with long term conditions was discussed at weekly clinical meetings to review treatment strategies and identify any required actions or changes. The practice had met with a local addiction service which meant they could now refer to a single point of contact, and they also met with health visitors regarding children who hadn't attended for immunisations to discuss possible safeguarding concerns. An external community healthcare professional we spoke with told us they felt the practice was engaged, and that the practice shared information and worked well with other agencies for the better care of patients.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated straight to the relevant doctor. If it a paper copy was received it was scanned into the patient's record. There was a system to ensure scanned documents were not sent to a doctor who was on leave, and the GP's operated a duty doctor system to check each other's results if one was off. The GP recorded their actions around results and arranged to see the patient if clinically necessary.

There was a local practice manager's forum which was attended, and the practice had shared audit findings with others via the CCG for shared learning.

Information from out of hours services was disseminated by reception staff to the appropriate GP who checked as a first task each morning. The practice kept 'do not resuscitate' and advance decision registers to reflect patient's wishes, and also those on palliative care or undergoing a mental health crisis. This information was made available to out of hours providers. The practice was sourcing mobile devices so that electronic patient information could be made available to GP's whilst on home visits.

Information Sharing

Information was shared between staff at the practice by a variety of means. Daily tasks highlighted any urgent issues; while there was a rolling programme of weekly and monthly practice meetings specific to the staff attending. Clinical and palliative care meetings were held and patient's clinical needs were discussed and information shared with relevant practice staff and with other healthcare professionals to ensure continuity of care for the patient. Staff were kept up to date with all aspects of the practice with regular practice meetings.

There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. Other information coming into the practice such as discharge letters who appropriately coded and then entered into the patient's electronic record. This ensured information from other health care providers was available to clinicians.

Consent to care and treatment

We found that staff had received training around the Mental Capacity Act 2005 and deprivation of liberty safeguards, and were able to describe key aspects of the legislation and their duties of fulfilling this in their roles.

There was a practice policy on consent to support staff and staff knew how to access this, and were able to provide examples of how they dealt with a situation if someone hadn't been able to give consent, including escalating this for further advice to a senior member of staff where necessary. The provider had audited their consent policy and identified where some improvements could be made, to include specific reference to Fraser guidelines, which are legal terms used to determine a child's rights and wishes.

Staff were able to discuss the carer's role and decision making process. Verbal consent was documented on the computer as part of a consultation. Consent forms and patient leaflets were available on the practice computer system for invasive procedures such as minor operations, coil fitting and smear tests. The forms detailed risks, benefits and potential complications, which enabled patients to make an informed choice.

Good

Are services effective?

(for example, treatment is effective)

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

The practice offered all new patients a nurse consultation to assess their past medical history, care needs and assessment of risk. The needs of new patients were assessed and a plan of the person's ongoing needs to stay healthy was developed. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to other services as necessary. The GP was informed of all health concerns detected and these were followed-up in a timely manner. A number of focussed health checks were available, including teenage contraception and sexual health advice, NHS health checks and stop smoking clinics. Women were offered health checks opportunistically when they attended for smears, contraception and hormone replacement therapy (HRT) reviews.

We found that the staff proactively assessed patients to identify any potential problems that may develop. GPs used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. Patients were signposted to leaflets and health information online. The practice linked into national campaigns such as bowel cancer screening and advertised these through their website and patient newsletters.

The practice aimed to identify people who may need extra support, for instance they actively sought information on who was acting as a carer from information around unplanned admissions or attendance at appointments so they could be signposted to additional support services.

In addition to routine immunisations the practice offered travel vaccines, and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders for childhood immunisations.

The practice's performance for cervical smear uptake was 80.2% which was just above the national target. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The practice kept a register of all patients with learning disabilities and these patients were offered an annual physical health check. 85.7% of eligible patients in this group had received cervical screening in the last five years, which was above the national target.

The practice had identified there was a waiting list for mental health services in the area so had made closer links with voluntary services and signposted to these, and were also involved in a scheme at a local training school referring patients to be seen where they wished by student counsellors under supervision of a qualified counsellor, which helped promote patients' mental health and welfare.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. In the 2012-13 National Patient Survey 89.9% of patients described their overall experience as good or very good, with 87.6% saying they were treated with care and respect by the doctor, both these figures being above the national average.

The practice had carried out patient surveys with input from the patient participation group (PPG) both before and after the merger with another local practice, which took place in January 2014. Of 232 responses in September 2013, 92% of patients said the GP listened to them either very well or extremely well; this figure stayed the same at 92% in September 2014. In 2013, 92% of patients said their medical condition was explained well to them, this figure was 89% in 2014. In 2013 97.5% of patients described reception staff as very or extremely friendly and in 2014 the figure was 92%. This shows that the practice maintained a service patients were happy with throughout and after the merger. Reception staff told us they took pride in providing a good customer service.

The practice participated in the 'Friends and Family' test, and patients could access a survey via a link on the practice website, which had 12 reviews. Whilst overall the surgery had received a rating of 4.5 stars out of five, there were some negative comments about patients not being able to get an appointment with the GP of their choice.

Patients completed 22 CQC comment cards to provide us with feedback on the practice, we spoke with a representative from the PPG, and also spoke with a further three patients during the inspection. The majority of people said they found the doctors, nurses and other clinical staff to be caring, empathetic and professional, and they treated them with dignity and respect. Some patients said they had been worried about the change with the merger but now felt better as they felt services had been maintained and in some cases, improved.

The most common negative feedback from comment cards, talking with patients and the practice's own surveys was the wait to get an appointment to see the GP of choice.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice phones were located away from the reception desk and were shielded by an internal door and glass partitions which helped keep patient information private. There was a room available where patients could speak with a receptionist in private if desired.

We saw the provider had confidentiality and chaperone policies in place and the staff we spoke with were aware of these. Some staff had received specialist chaperone training. We did note that while the chaperone service was referred to in the practice leaflet, there was no poster in reception making patients aware of the service.

Care planning and involvement in decisions about care and treatment

85.2% of people in the national patient survey results for the practice said they were involved in decisions about their care, which was above the national average of 81.8%. The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. For example, nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin.

Nursing staff described a partnership approach to care planning with the patient, for example with a new diagnosis of diabetes, treatment goals were documented on the care plan in conjunction and in discussion with the patient.

People said the GPs explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment

Good

Are services caring?

they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Similar comments were received on the CQC comment cards.

Staff told us there were either telephone translation or interpreter services available for those whose first language was not English, and we saw details for this service.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support services to help them manage their treatment and care. CQC comment cards filled in by patients said doctors and nurses provided a caring empathetic service.

GPs referred people to bereavement or mental health counselling services where necessary. There were no specific leaflets advertising these services in reception, however the practice leaflet did signpost patients to bereavement support provided by Macmillan nurses. The practice website contained some telephone numbers for support organisations in the local area, and the computer system alerted the GP if a patient was also a carer. The practice proactively sought to identify carers, including young carers, and information and signposting was provided in the practice leaflet.

Staff told us families who had suffered bereavement were called by either their usual GP or a senior clinician. This call was either followed by a patient consultation to meet the family's needs and/or signposting to a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and the practice had reviewed extensively data for patients who had joined the practice in the merger. We found they had identified, patients that were overdue reviews for long term conditions. Systems were in place to address identified needs. The practice used a risk stratification tool to identify patients who may be at risk, for example of unplanned emergency admissions to hospital. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients' and their families care and support needs.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities. Longer appointments could be made available for those with complex needs. Home visits were available, for instance for older people or those with long term conditions who would find it difficult to attend a surgery, and could be carried out by GPs, nurses and nurse practitioners.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow these up by telephone and letter. Medication reviews were individually considered by GPs according to the type of medicine and the patient, this cut down the number of times a patient needed to contact or attend the surgery for medicines.

The facilities and premises coped with the services which were planned and delivered, with sufficient treatment rooms and equipment available, although some clinical staff did say they were occasionally not able to make best use of their skills for instance developing specialist clinics, due to a lack of treatment rooms and the need for a room rota. This was recognised by the provider as a consequence of the practice doubling in size, and the provider was actively engaged in sourcing new premises.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as ramped access and level thresholds. Treatment and consulting rooms, and patient toilets were on the ground floor.

The practice leaflet and mission statement promoted diversity and stated that patients would be welcomed without discrimination. Telephone or online translation services could be accessed where necessary. There was no hearing loop installed for those hard of hearing, however staff explained they dealt with this by taking patients into a private room or writing things down, which they felt promoted patient confidentiality.

The practice had registers of people who may be living in vulnerable circumstances and those with learning difficulties, and staff were able to give examples of how these helped them deal sensitively with patients, for instance offering longer appointments.

Access to the service

Patients could make appointments by telephone, calling at the surgery, or online. Repeat prescriptions could be ordered online. The practice had extended its opening hours in response to increased patient numbers as a result of the merger, and was open from 8am until 8pm five days a week. This also helped patients access the service who worked during the day.

Opening times and closures were advertised on the practice website, with an explanation of what services were available. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

The practice operated a nurse triage system for urgent calls, where people needed an appointment the same day. Following a clinical assessment by the nurse on the phone patients could be given advice, an appointment to attend the surgery, or a home visit arranged. Patients told us this system worked well and they had been able to access same day appointments when they required them.

Patients said the appointments system generally worked well for them, although there was some negative feedback

Good

Are services responsive to people's needs?

(for example, to feedback?)

about having a longer wait to see their GP of choice, although patients could always access a GP when required. Telephone consultation appointments were also available.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice, in this case the practice manager initially handled complaints. Information on how to complain was contained in the patient leaflet, on the practice website, and was displayed in reception.

There was a suggestion box and further information which encouraged patients to leave feedback. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

We looked at a summary of complaints from the previous year, and could see that these had been responded to in a timely manner, and a full investigation undertaken. The patient was then contacted with a full explanation and where necessary an apology. Details of the ombudsman had been made available if people were not happy with the outcome of the complaint investigation.

The practice summarised and discussed complaints at practice meetings, or where necessary on a one to one basis with staff members or as part of their appraisal. The practice was able to demonstrate learning and changes as a result of complaints, such as rewriting of practice information or retraining a member of staff, and we saw minutes of meetings where shared learning and action points were discussed.

Patients we spoke to said they would feel comfortable raising a complaint if the need arose, and knew how to raise a complaint.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear mission statement which was on patient leaflets. The mission statement promoted diversity, good communication, and the best possible health outcomes for patients. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Achievement of this vision had been monitored through the merger process by QOF data reporting, a patient survey, and PPG feedback.

Staff told us they informed and involved throughout the merger and had presented a genuinely positive image to patients who were worried how the change would affect their service. Staff told us they understood the values of the practice, particularly in relation to providing good customer service.

Action plans and an annual report were produced in conjunction with the PPG following patient surveys, and these were published on the website. These included areas of priority for the PPG, with specific targets such as increasing awareness of the triage system and monitoring the effect of new staff recruitment on appointment availability.

Governance Arrangements

Staff were clear on their roles and responsibilities, and said they felt able to communicate with doctors or the practice manager if they were asked to do something they felt they were not competent in. There was only one GP partner who oversaw the practice and all other staff were salaried, however all staff we spoke with reported they felt supported by and involved in the practice, and had a clear understanding of their roles.

There were clear systems in place to monitor and record quality assurance and performance. Audits on subjects such as infection control, equipment checks, and repeat prescribing had been carried out. Each audit had a specific member of staff with allocated responsibility and detailed completed dates and actions taken.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer. Staff knew where to locate these. Policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance, practice and clinical meetings. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for instance for patients using the building, fire, and cleaning products.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The practice had reported data monthly to the CCG during the merger to ensure patient outcomes were monitored closely throughout the change. Latest QOF figures showed that while there had been a short-term impact in some areas, in general figures were improving. The practice had identified areas for improvement and were working to improve patient outcomes, for instance by initiating long term condition or medication reviews.

The practice had identified lead roles for areas of clinical interest, safeguarding, or management tasks, and had produced an action plan for the future. There was a programme of clinical audit, with subjects selected from QOF outcomes, from data cleansing exercises within the practice, from the CCG, or from incidents or GP's own reflection of practice. While these audits reported on findings, not all audits we looked at had a clear action plan with timescales, people identified who would carry out the actions, and a timescale for re-audit.

From our discussions with staff we found that they looked to continuously improve the service being offered. We saw evidence that they used data from various sources including incidents, complaints and audits to identify areas where improvements could be made.

We saw evidence that there were systems in place to identify poor performance across the staff team, and saw an example where following poor performance being identified, this was investigated and dealt with appropriately.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service. Staff described the culture at the practice as open and honest, and said they felt confident in raising concerns or feedback, and were all clear about their own roles and

Are services well-led?

Good

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

responsibilities. They all told us that felt valued and well supported, and gave examples of issues they had raised. Staff described communication throughout the practice as excellent.

We saw from minutes that team meetings were held monthly, in addition to clinical and multi-disciplinary meetings, and these incorporated strategic objectives and planning. Staff told us they had the opportunity and were happy to raise issues at team meetings. Action points and minutes were disseminated by email after the meetings. An analysis of strengths and weaknesses of the current operating model had taken place, and the provider was actively engaged in succession planning to maintain services for the future.

There was a clear chain of command and staff knew who to raise issues with. The practice had successfully integrated two separate teams of staff through the merger and staff morale had remained high. Staff told us they were kept informed throughout the process. A staff handbook was available which had policies relating to equality and diversity, bullying and performance issues. Staff we spoke with knew where to find these policies if required.

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

There was an active Patient Participation Group (PPG), which met quarterly, and annual patient survey reports and action plans were published on the practice website for the practice population to read. The PPG was chaired by the practice manager at the request of the PPG members. The practice was actively advertising to recruit younger members to the group to ensure it was representative of the practice population.

We saw several examples where the practice had made changes as a result of patient feedback and in conjunction with the PPG, for instance, how to better communicate how the appointment and triage system worked. The action plan completed from the patient survey included survey comments and PPG views.

Members from the PPG also attended CCG Patient Forum meetings, which allowed sharing of good practice. A representative of the PPG told us they felt involved and engaged with the practice as a group, and that their views were listened to. A monthly newsletter was produced for patients to keep them informed of changes. In addition to patient surveys, there was a suggestion box in reception and a link on the practice website to the 'Friends and Family' test, giving patients the opportunity to leave public reviews and feedback.

Staff at all levels told us they felt confident giving feedback, and were actively encouraged to do so. This was recorded through staff meetings or the appraisal process.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to attend training where required and ask for additional specialist training. However there was no structured, regular protected learning time sessions. We looked at three staff files which showed that appraisals took place where staff could identify learning objectives and training needs. GPs were appraised both internally, and externally as part of their revalidation process.

Training records we looked at showed staff were up to date with mandatory training. The practice had completed reviews of significant events and other incidents, and shared these with staff via team meeting discussions to ensure the practice improved outcomes for patients. Staff told us the culture at the practice was one of continuous learning and improvement.