Barnfield Hill 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Barnfield Hill Surgery was inspected on Wednesday 1 October 2014. This was a comprehensive inspection.

Barnfield Hill provides primary medical services to people living in the city of Exeter, Devon and the surrounding areas. The practice provides services to a diverse population and is situated in a city centre location.

At the time of our inspection there were approximately 7,300 patients registered at the service with a team of six GP partners. GP partners held managerial and financial responsibility for running the business. In addition there was an additional salaried GP, three registered nurses, a phlebotomist, a practice manager, and additional administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Our key findings were as follows:

We rated this practice as good. Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

The practice valued feedback from patients and acted upon this. Feedback from patients about their care and treatment was consistently positive. We observed a patient centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and were aligned with our findings.

The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

Summary of findings

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's mental capacity to make an informed decision about their care and treatment, and the promotion of good health.

Suitable staff recruitment, pre-employment checks, induction and appraisal processes were in place and had been carried out. Staff had received training appropriate to their roles and further training needs had been identified and planned.

Information received about the practice prior to and during the inspection demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients told us they felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was communicated and acted upon, although the written evidence for this process did not always consistently show what learning and actions had taken place following such investigations.

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

The provider should:

Improve record keeping from accidents, significant events and complaints to show learning and actions taken.

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 good for being safe. Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

The practice had systems to help ensure patient safety and staff had appropriately responded to emergencies.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. Risk assessments had been undertaken to support the decision not to perform a criminal records check for administration staff.

Significant events and incidents were investigated both informally and formally. Staff were aware of the learning and actions taken however, records did not consistently show the outcome or that learning and actions had been taken forward following such investigations.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults from the risk of abuse. However, the child safeguarding procedures and information required updating.

There were suitable arrangements for the efficient management of medicines within the practice.

The practice was visibly clean, tidy and hygienic. Suitable arrangements were in place to maintain the cleanliness of the practice. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated good for being effective. Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run.

Summary of findings

The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice.

Information obtained both during and after the inspection showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation had been completed.

The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for being caring. Data showed patients rated the practice higher than others for many aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Patients spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them about their physical, mental and emotional health and supported their health education.

Patients told us they were included in the decision making process about their care and had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations, or through any subsequent diagnosis and treatment.

Are services responsive to people's needs?

Good

The practice was rated good for being responsive. Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

Patients told us they did not need to complain. There was information provided on how patients could complain although access to this information on the practice website could be

Summary of findings

improved. Complaints were managed according to the practice policy and within timescales. However, records kept regarding complaints did not consistently show the outcome or any learning or actions that had been taken following such investigations.

The practice recognised the importance of patient feedback and had encouraged the development of a patient participation group to gain patients' views.

Practice staff had identified that not all patients found it easy to understand the care and treatment provided to them and made sure these patients were provided with relevant information in a way they understood.

Patients said it was easy to get an appointment at the practice and were able to see a GP on the same day if it was urgent.

Are services well-led?

Good

The practice is rated as good for being well led. The practice had a vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Nursing staff, GPs and administrative staff demonstrated they understood their responsibilities including how and to whom they should escalate any concerns.

Staff spoke very positively about working at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

The practice had a number of policies to govern the procedures carried out by staff and regular governance meetings had taken place. There was a programme of clinical audit in operation with clinical risk management tools used to minimise any risks to patients, staff and visitors.

Significant events, incidents and complaints were managed as they occurred and through a more formal process to identify, assess and manage risks to the health, welfare and safety of patients. However, records did not always reflect what learning and actions had taken place and communicated to staff.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated good for older people. Patients aged 75 and over had an allocated GP and could also see an alternative GP if they preferred. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people during routine appointments or at weekends. Vaccines for older people who had problems getting to the practice or those in local care homes were administered in the community by the practice nurses. Nurses and GPs undertook home visits for older people and for patients who required a visit following discharge from hospital.

Clinics specifically for older people were not held at the practice, but treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for older people approaching the end of life. This included a community matron for the elderly in the community. The practice website included a number of links containing extensive information about the promotion of health for conditions which affect older people.

The practice worked jointly with other health care professionals to avoid unnecessary admissions to hospital. This included liaison with staff in the acute community team providing support in the patient's home for short term treatment and rehabilitation. The GPs worked with consultant geriatricians for advice on the best treatment and support for older patients.

People with long term conditions

Good

The practice is rated good for patients with long term conditions.

The practice identified patients with multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. The staff at the practice maintained links with external health care professionals for advice and guidance.

Patients with long term conditions had tailor-made care plans in place. Patients were pleased with the care they received for their long term conditions and were offered clinics at a time convenient to them for monitoring and treatment of conditions. These included diabetes, heart failure, hypertension, high cholesterol, renal failure,

asthma and chronic respiratory conditions. The nurses attended educational updates to make sure their lead role knowledge and skills were up to date. Practice staff also involved healthcare specialists for advice where appropriate.

Appointments were available for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients. Patients were supported with weight management and referrals to dieticians were made where appropriate.

The practice had worked with two other GP practices to provide a strollers group for patients who wanted to improve their fitness but were not quite ready for other community fitness groups. Patients could also be referred by the GP to a gym membership scheme.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style. The practice also held a virtual diabetic clinic with two other GP practices and a hospital diabetic consultant. This was a forum where complex cases could be discussed confidentially with the specialist, while GPs received guidance on the management of complex cases.

Home visits and medicine reviews were provided for patients with long term conditions who had been recently discharged from hospital.

Patients receiving certain medicines were able to access screening services at the practice to make sure the medicines they received was effective.

The practice used a specific computerised patient record system allowing out of hours service providers to access information on specific patients so the treatment was seamless for the patient. GPs and out of hours doctors were then aware of any treatment that had been given to people with long term conditions or those at the end of their life.

The practice had links with a voluntary service which provided transport services for patients should this be required.

Families, children and young people
The practice is rated good for families and young people.

Good

Summary of findings

Parents we spoke with were very happy with the care their families received.

There were well organised baby and child immunisation programmes available to ensure babies and children could access a full range of vaccinations and health screening.

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held clinics at the practice. The midwives had access to the practice computer system and could speak with a GP should the need arise. The practice also had established relationships with health visitors and the school nursing team, and were able to access support from children's workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

The practice referred patients and worked closely with a local family and child service to discuss any vulnerable babies, children or families.

One of the GPs at the practice was the medical officer for a local school for deaf children and visited the school on request or if required.

Young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. Patients could also be referred to the specialist sexual health clinic in the city for more complex sexual health screening and treatment. There were quiet private areas in the practice for women to use when breastfeeding.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Working age people (including those recently retired and students)

Good

The practice is rated good for working age people, those recently retired and students.

Patients who were of working age or who had recently retired were pleased with the care and treatment they received.

Summary of findings

Advance appointments (up to six months in advance), early morning and evening appointments were available twice a week to assist patients not able to access appointments due to their working hours. The practice also used a text message reminder service for some patients.

There was a newly set up patient participation group at the practice whose membership reflected the working age and recently retired age group of patients at the practice.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available. Pneumococcal vaccination and shingles vaccinations were provided for at risk patients either at the practice during routine appointments or at weekends for patients who found it difficult to access the practice during office hours.

The staff carried out opportunistic health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. The practice also offered age appropriate screening tests including prostate and cholesterol testing.

Patients who received repeat medicines were able to collect their prescription at a place of their choice. The practice had recently introduced an electronic prescribing system which sent the approved prescription directly to the pharmacy of the patient's choice. This was useful for patients who could not easily access the practice during office hours.

People whose circumstances may make them vulnerable

Good

The practice is rated good for people living in vulnerable circumstances.

The practice had a vulnerable patient register. These patients were reviewed monthly at the multidisciplinary team meetings.

Staff told us that there were a few patients who had a first language that was not English. Patients with interpretation requirements were known to the practice and staff knew how to access these services.

Patients with learning disabilities were offered and provided with a health check every year, during which their long term care plans were discussed with the patient and their carer if appropriate.

Summary of findings

Practice staff were able to refer patients to an alcohol service for support and treatment if required. The support service visited the practice if the patient chose this. The practice did not provide primary care services for patients who were homeless. This was because there was a specific GP practice for homeless people in the area. However, staff said they would not turn away a patient if they needed primary care and could not access it.

The GP liaised with the community matron who visited vulnerable patients in their homes to assess their needs and facilitate provision of any equipment, mobility or medicines.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for people experiencing poor mental health.

A GP had been named as having a particular interest in caring for patients with mental health issues. However, all GPs cared for mental health patients on their personal list. A register at the practice identified patients who had mental health problems.

Patients had access to a counsellor provided by the practice and were offered ongoing support by the counsellor and GPs. Patients who had depression were seen regularly and were followed up if they did not attend appointments.

Mental health medication reviews were conducted to ensure that patients' medicines remained appropriate and that the dose was still correct. Blood tests were regularly performed on patients receiving certain mental health medicines to provide the GP with the information they needed to adjust the dosage.

There was communication, referral and liaison with a psychiatry specialist who offered advice and support. The GPs could refer patients for mental health assessment and also treatment for older patients who had mental health issues. This included advice and assessments for patients with dementia.

GPs and nurses were aware of the Mental Capacity Act 2005 and had received training on this or were in the process of organising their own training. The practice was using nationally recognised examination tools to assess people who were displaying signs of dementia.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. We spoke with three representatives of the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the

inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 18 comment cards which contained detailed positive comments.

Comment cards stated that patients were grateful for the caring attitude of the staff and for the staff who took time to listen effectively. Comments also highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were excellent.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients appreciated the service provided and told us they had no complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the website was good.

Areas for improvement

Action the service SHOULD take to improve

The record keeping from accidents, significant events and complaints should be improved to show learning and actions taken.

Barnfield Hill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Barnfield Hill Surgery

At the time of our inspection there were approximately 7,300 patients registered at the service with a team of six GP partners. GP partners held managerial and financial responsibility for running the business. In addition there was an additional salaried GP, three registered nurses, a phlebotomist, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

Barnfield Hill Surgery is open between Monday and Friday: 8.30am – 5pm with 7.30am morning appointments twice a week and evening appointments up to 7.30pm available twice a week. These are pre-bookable appointments designed to be used by patients going to work.

Outside of these hours a service is provided by another health care provider by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to six months in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting Barnfield Hill Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 1 October 2014. We spoke with nine patients and 14 staff at the practice during our inspection and collected 18 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, four GPs,

receptionists/clerical staff, practice nurses and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with three representatives from the patient participation group (PPG).

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff. Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that these three monthly meetings were well structured, well attended and not hierarchical.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

Learning and improvement from safety incidents

At Barnfield Hill the process following a significant event or complaint was both informal and formalised. GPs discussed incidents daily and also three monthly at clinical meetings. GPs, nurses and practice staff were able to explain the learning from these events but records kept did not always reflect this knowledge meaning that it would not be easy to establish whether learning points and actions were known and adopted by the practice as a whole. Within 24 hours the practice manager had sent us a new template to capture this information.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients, young patients and children. They had been trained to the appropriate advanced level. There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them.

However, the child safeguarding information folder contained some historical information which could confuse staff. The manager sent confirmation within 48 hours that this folder had been reviewed.

There were monthly multidisciplinary team meetings with relevant attached health professionals including social workers, district nurses, palliative care, physiotherapist and occupational therapists where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings.

We spoke with two external health care professionals who said communication with the practice staff was excellent and collaborative working was effective.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult or 'at risk' child had been seen by different health professionals, staff were aware of their circumstances. Staff had received safeguarding training and were aware of who the safeguarding leads were. Staff also demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or safeguarding policy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required.

The practice had a written policy and guidance for providing a chaperone for patients which included expectations of how staff were to provide assistance. Administration staff at the practice acted as chaperones as

required. They understood their role was to reassure and observe that interactions between patients and doctors were appropriate and record any issues in the patient records.

Medicines Management

The GPs were responsible for prescribing medicines at the practice. There were no nurse prescribers employed.

The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the surgery, send an e-mail, or use the on-line request facility for repeat prescriptions.

Other medicines stored on site were also managed well. There were effective systems in place for obtaining, using, safekeeping, storing and supplying medicines. Clear checks and temperature records were kept to strengthen the audit of medicines issued and improve medicine management.

All of the medicines we saw were in date. Storage areas were clean and well ordered. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. This meant the cold chain and effective storage was well maintained. We looked at the storage facilities for refrigerated medicines and immunisations, the refrigerator plug was not easily accessible therefore was very unlikely to be switched off.

Patients were informed of the reason for any medicines prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medicine to check for side effects.

The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patient's medicines were authorised by the prescriber.

Systems were in place so that checks took place to ensure products were kept within expiry dates. Those medicines which required refrigeration were stored in secure fridges. Fridge temperatures were monitored daily to ensure that medicines remained effective.

There were no controlled drugs (CD) stored at the practice. However, appropriate CD storage facilities and registers were in place should they be required.

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received 18 completed cards. Of these, six specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands.

The practice had policies and procedures on infection control. We spoke with the infection control lead nurse. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out and monitored. There were hand washing posters on display to show effective handwashing techniques.

Clinical waste and sharps were being disposed of in safely. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Are services safe?

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in January 2013.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. The practice said they used locums as staff cover but tried to use the same one for continuity. GPs told us they also covered for each other during shorter staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Each team had appointed clerical support. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal record checks were only performed for GPs, nursing staff and administrative staff who had direct access with patients. Recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check.

The practice had disciplinary procedures to follow should the need arise.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan that documented the practice's response to any prolonged events that may compromise patient safety. For example, this included computer loss and lists of essential equipment.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents.

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had also been included on the basic life support training sessions.

During the inspection, emergency procedures were demonstrated when an emergency occurred with a patient. The GP, nurse and reception staff professionally and calmly dealt with the patient and situation, ensuring patient comfort, reassurance and privacy until safe transfer to hospital.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Clinical Excellence (NICE) guidance and had formal meetings to discuss latest guidance. Where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area.

Management, monitoring and improving outcomes for people

The practice provided a service to up to 7,300 patients. The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including immunisation, diabetes care, cervical screening and travel vaccinations.

The GPs referred patients to staff in the acute community team, who provided support in the patient's home for short term treatment and rehabilitation. This enabled patients to remain at home and to be treated for a short period of time, avoiding a hospital admission where appropriate.

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes.

Effective Staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. One of the GPs was a nominated GP for appraising other GPs in the county.

The practice was a teaching practice for new GPs. One of the GPs was a course organiser on the GP vocational training scheme and was a trainer for trainee GPs.

Nursing staff had received an annual formal appraisal and kept up to date with their continuous professional development programme, documented evidence to confirmed this. A process was also in place which showed clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for each staff role.

The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff said that they could ask to attend any relevant external training to further their development.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

The practice worked effectively with other services. Examples given were mental health services, health visitors, specialist nurses, hospital consultants and community nursing. For example, the GPs met with a diabetic consultant to discuss complex diabetic cases and worked with community psychiatric nursing teams when caring for patients with mental illness.

Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Are services effective?

(for example, treatment is effective)

Communication with the out of hours service was good as the Out of Hours GPs were able to access patient records with their consent, using a local computer system. The practice GPs were informed when patients were discharged from hospital. This prompted a medication review.

The practice were working collaboratively with hospital diabetic specialist which meant patients did not need to visit the hospital but still received advanced specialist care. The GPs also benefitted by receiving education on the management patients with complex diabetic needs

Information Sharing

The practice worked effectively with other services. Examples given were mental health services, health visitors, specialist nurses, hospital consultants and community nursing staff. For example, the GPs shared relevant information with health visitors regarding children in need.

Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback given on our comment cards showed that patients had different treatment options discussed with them, together with the positive or possible negative effects that treatment can have.

Staff had access to different ways of recording that patients had given consent to treatment. There was evidence of patient consent for procedures including immunisations, injections, and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject. We were given specific examples by the GPs where they had been involved in best interest decisions and where they had involved independent mental capacity assessors to ensure the decision being made regarding the patient who could not decide themselves, was in the patient's best interest.

Health Promotion and Prevention

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. A full range of screening tests were offered for diseases such as prostate cancer, cervical cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Patients were encouraged to adopt healthy lifestyles and were supported by services such as a walking group and smoking cessation clinics. Patients with diabetes were invited to a 'tea for two' clinic where staff discussed how changes to lifestyle, diet and weight could influence their diabetes.

All patients with learning disability were offered a physical health check each year. This was arranged in the patient's birthday month.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

The practice recognised the need to maintain fitness and healthy weight management. The practice worked with a small number of other practices to provide a walking group for patients who did not feel confident to join the city walking group. Patients had also been referred to exercise programmes and gyms.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. Website links were easy to locate.

Family planning, contraception and sexual health screening was provided at the practice.

The practice offered a full travel vaccination service and were a nominated yellow fever centre.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received or about the staff.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 18 completed cards which contained very detailed positive comments. All comment cards stated that patients were grateful for the caring attitude of the staff who took time to listen effectively.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who is present with a patient during consultation, examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Administration staff at the practice acted as chaperones as required. They understood their role was to reassure and observe that interactions between patients and doctors were appropriate.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an ongoing dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and ongoing care arranged by practice staff. We were given specific examples where the GPs and nurses had taken extra time and care to diagnose complex conditions.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 91% of the 192 respondents in the 2013 survey stated that they were treated with kindness and care. The patients we spoke to and the comment cards we received were consistent with this information.

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours, or 48 hours if test results were routine. Patients said they had not experienced delays receiving test results.

The practice was responsive to patient needs. We were given an example of a patient who was registered blind and required secondary care. The patient had been supported by the GP, who had telephoned them to ensure they understood the treatment planned by the hospital consultant and understood about the changes in medication.

A new patient participation group (PPG) had recently been set up. Members of this group were keen to become involved at the practice and said they had already been consulted about a new information screen to be introduced. The PPG members said they were encouraged to contribute suggestions.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away, there were no homeless patients registered at the practice because there was a specific GP service for homeless people in the city.

The number of patients with a first language other than English was low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The patient participation group (PPG) were working to recruit patients from different backgrounds to reflect the diversity of the practice.

General access to the building was good. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. The majority of consulting rooms had level access. There was no lift in the building. Alternative treatment rooms and office space was available for patients and staff who were unable to use stairs.

There was no evidence of discrimination when making care and treatment decisions. For example we were given a specific example from a patient in a same sex relationship of being treated fairly and in a non-discriminatory way regarding a health and life style matter.

Access to the service

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. Of the 18 comment cards we received, one mentioned that getting an appointment at a time that was convenient to them was sometimes difficult. However, all other comments, discussions and feedback indicated that patients were happy with the arrangements for access.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

A 2012/2013 national patient survey showed that 93.8% of the respondents rated their experience of getting an appointment as good or very good. This was higher than the national average.

These findings were reflected during our conversations. Patients were happy with the appointment system and said they could get a same day appointment if necessary.

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by a poster displayed in the practice, on the website and on the telephone answering message.

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns.

Patients told us they had no complaints and could not imagine needing to complain. Not all patients were aware of how to make a complaint but said they felt confident that any issues would be managed well.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the surgery welcomed patient opinion by sharing ideas, suggestions, views, and concerns, however, this information was less obvious.

The complaints procedure stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at the clinical meetings held every three months. The records kept of these meetings or the complaints register did not always evidence the learning or actions taken and did not reflect what staff explained had occurred.

Are services well-led?

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

Our findings

Vision and strategy

The practice vision was to deliver high quality care and promote good outcomes for patients. Staff knew and understood the vision and values and knew what their responsibilities were in relation to these.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and many staff had worked at the practice for many years and were positive about the open culture.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Staff said the practice was small enough to communicate informally through day to day events and more formally though meetings and formal staff appraisal.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal. Issues were discussed amongst staff as they arose, for example, GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. These issues were then followed up more formally at three monthly clinical meetings where standing agenda items included significant events, near misses, complaints and health and safety. Staff explained these meetings were well structured, well attended and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for Barnfield Hill Surgery were consistently above the national average.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. In addition to the incentive led audits the GPs told us they wanted to perform audits to improve the service for patients and not just for their revalidation or QOF scores. These examples included medication audits, audits on complications following insertion of devices for intrauterine contraception. Audits followed a complete audit cycle but were not readily available to provide a resource for trainees and other staff.

Leadership, openness and transparency

Staff were familiar with the leadership structure, which had named members of staff in lead roles. For example there was a lead nurse for infection control, a lead GP for safeguarding and a lead GP for the GP Vocational Training Scheme. Staff spoke about effective team working, clear roles and responsibilities and talked about a supportive non-hierarchical organisation. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Staff were aware of where to find these policies if required.

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

Patients we spoke with in the waiting room had not been formally asked for their views about the practice but they were aware there were suggestion boxes in the waiting room. The website signposted patients to give feedback if they chose.

The practice had a patient participation group (PPG), which had been set up earlier in the year. The three PPG members who came to the inspection said the practice manager and GP representative were keen to encourage patient feedback and involvement. The PPG said they had already been consulted about an information screen for the waiting room. The PPG members said they had been able to influence this decision and suggest additional ideas. The PPG was advertised on the practice website.

Management lead through learning & improvement

A process was followed so that learning and improvement could take place when events occurred or new information was provided. For example the practice held six monthly meetings to discuss any current hot topics and review any

Are services well-led?

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

newly released national guidelines and the impact for patients. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

There were environmental risk assessments for the building. For example annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been carried out. Health and safety items were a standing agenda item for the three monthly clinical meetings.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.