Berryfields Medical Centre

Quality Report

Colonel Grantham Avenue
Buckingham Park
Aylesbury
Buckinghamshire
HP19 9AP
Tel: 01296 310940
Website: www.berryfieldsmedicalcentre.co.uk

Date of inspection visit: 4 /12/ 2014
Date of publication: 19/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 4 December 2014 at Berryfields Medical Practice, Colonel Grantham Avenue, Buckingham Park, Aylesbury, Buckinghamshire, HP19 9AP.

We spoke with patients, staff and reviewed a range of documents relating to how the practice provided services as part of the inspection process.

Berryfields Medical Centre is rated overall as good.

Our key findings were as follows:

- The practice is rated as requires improvement for safe. This was due to the lack of information to ensure staff were safely recruited. There were systems in place to ensure safe patient care and learning took place following adverse events and incidents. The premises were clean and patients were protected from the risk of infection. Systems were in place to ensure medicines were appropriately stored, handled and prescribed.
- The practice is rated as good for effective. Patients' needs were assessed and care was planned and delivered in line with current guidance and legislation. The practice promoted health education to empower patients and improve self-care.
- The practice is rated as good for caring. Patients spoke highly of the practice. They said they were always treated with dignity and respect. Staff were kind, compassionate and caring and this was confirmed by national patient survey data.
- The practice is rated as good for responsive. The practice had a significantly higher proportion of patients under the age of nine years compared to the local average. The practice worked to develop its services to take into account the needs of their population groups. Although the practice did not offer extended hours patients generally reported good access to appointments.
- The practice is rated as good for well led. The practice worked hard to monitor, evaluate and improve

Summary of findings

services. They worked in collaboration with the Clinical Commissioning Group (CCG) to develop their services. Staff enjoyed working for the practice and felt well supported and valued.

There were also areas of the practice where the provider must make improvements, importantly, the provider must:

- Ensure that all the recruitment checks are carried out and recorded as part of the staff recruitment process.
- Ensure that criminal records checks through the Disclosure and Barring Service (DBS) or risk assessments are carried out.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. This was due to the lack of documented recruitment checks including proof of identity, a recent photograph and Disclosure and Barring Service checks for staff who carried out chaperone duties. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute of Care and Health Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the practice's development and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group or patient forum was active. Staff had received inductions, regular performance reviews and attended staff meetings and team building events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. The premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice was proactive in educating its patients. For example, one of GPs had provided a teaching session for parents to inform them about common signs of concern in their children and how to provide self-care appropriately.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for patients with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability. The practice worked with multidisciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Ninety seven per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice provided resources for patients experiencing poor mental health about how to access various support groups and voluntary organisations including the Mental Health Foundation and Alzheimer's Society.

Summary of findings

What people who use the service say

The 2014 national GP patient survey results for Berryfields Medical Centre based on 92 survey (31%) responses showed the practice was rated above or very close to the local average for all the measures. The practice scored highly on satisfaction of patients calling the practice and obtaining appointments.

During the inspection on 4 December 2014 we spoke with 12 patients. All the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Four out of 12 patients expressed some dissatisfaction with the time to obtain non-urgent appointments.

We received 18 completed comment cards. All of the comments except one were very positive about all aspects of the service provided. The one negative comment was brought to the attention of the practice and they were aware of the incident.

Areas for improvement

Action the service MUST take to improve

- Ensure that all the recruitment checks are carried out and recorded as part of the staff recruitment process.
- Ensure that criminal records checks through the Disclosure and Barring Service (DBS) or DBS risk assessments are carried out.

Berryfields Medical Centre

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, a specialist in practice management and an Expert by Experience.

Background to Berryfields Medical Centre

Berryfields Medical Centre is located in a purpose built portacabin in an urban area of Aylesbury, Buckinghamshire. The practice is owned by BK Health Limited and has been providing primary medical care to patients in the local area since 2008. The provider plans to relocate the practice to purpose built premises in the area of Berryfields, (an area of redevelopment with business and residential premises) a few miles away in 2015. The practice holds a personal medical services (PMS) contract to provide primary medical services to approximately 4200 registered patients. The practice list size has steadily increased by approximately 1000 patients each year over the last two years and this increase is expected to continue to a maximum of 13 000 patients by 2019 when it relocates. National data indicates the practice serves a population which appears to be more affluent than the national average. However, there are also less affluent population groups due to the changing demographics in the area. The practice also has a different age profile to the local clinical commissioning group average. It has a significantly higher proportion of patients under the age of nine years and between the ages of 25-39 years and a lower proportion under 45 years.

The practice has three GP salaried partners and one salaried GP: three female and one male. The practice has recently been accredited as a training practice, although at the time of inspection no trainee was in post. The practice employs a team of three nursing staff, one of whom is a nurse prescriber. GPs and nurses are supported by the two practice managers and a team of reception and administration staff; a total 15 staff.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements for patients to access care from an out-of-hours provider.

The announced, comprehensive inspection at Berryfields Medical Centre, Colonel Grantham Avenue, Buckingham Park, Aylesbury, Buckinghamshire HP19 9AP took place on 4 December 2014.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

Detailed findings

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

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Prior to the inspection we contacted the Aylesbury Vale Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Berryfields Medical Centre. We also spent time reviewing information that we hold about this practice.

The inspection team carried out an announced visit on 4 December 2014. We spoke with 12 patients and 11 staff. We also reviewed 18 comment cards from patients who shared their views and experiences.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including GPs, nursing staff, managers and administration and reception staff.

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

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

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

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

The practice serves a population which appears to be more affluent than the national average and has a different age profile to the local clinical commissioning group average. It has a significantly higher proportion of patients under the age of nine years and between the ages of 25-39 years and lower proportion under 45 years.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, one reported incident involved lack of communication and access to the community nursing service for a palliative care patient.

We reviewed safety records, incident reports and notes of meetings where incidents had been discussed for the last year. This showed the practice had managed these consistently over time and showed evidence of a safe track record over the last year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. 'Significant events' was a standing item on the practice meeting agenda and a dedicated meeting was held every two months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms, accessible on the practice intranet and sent completed forms to the practice manager. We reviewed four incidents that had been reported in the last 12 months and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example, a recent incident involved the vaccine fridge being left open inadvertently and a consequent loss of vaccines. Staff were reminded to lock the fridge after use and they told us more diligent checking took place to ensure the fridge was locked at all times.

National patient safety alerts were disseminated by the practice manager to staff, usually nursing staff for action. Actions taken where recorded as an audit trail and discussed at clinical meetings, if appropriate. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, a safety alert received in April 2014, relating to a medicine had resulted in an audit and on going monitoring of it to reduce the risk of adverse drug reactions.

Reliable safety systems and processes including safeguarding

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

The practice had a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (for example, all GPs had level three training in safeguarding children). All staff we spoke with were aware who the lead was and were aware who to speak with in the practice if they had a safeguarding concern. GPs had close contact with health visitors and met with them every two months to discuss vulnerable children and those who had child protection plans in place. We saw actions and progress was recorded in the notes of these meetings.

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

There was a chaperone policy in place and notices in the consulting rooms to inform patients. GPs routinely offered a chaperone for all intimate examinations and we saw it was recorded in the patient notes. Nursing staff, including health care assistants, had been trained to be a chaperone.

Requires improvement

Are services safe?

If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Children who failed to attend appointments, for example, for childhood immunisations were followed up by a staff member. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy which had been enacted recently following an incident.

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.

The practice had a GP lead for prescribing who monitored and reviewed prescribing matters. This was confirmed by the notes of a recent clinical meeting which focussed on a range of medicines management including the budget and prescribing patterns.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of samples of patient group directions and patient specific directions for nurses and the health care assistant, who had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. A repeat prescribing policy was in place and reviewed regularly.

The practice used the electronic prescription service; over half the prescriptions were issued electronically.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. We spoke with 12 patients they all told us they thought the practice was clean and had no concerns about cleanliness or infection control during their visits.

The practice had a lead for infection control who had undertaken further training and was part of the local infection control group. They provided advice on the practice infection control policy and carried out staff training. All staff received induction training about infection control specific to their role and received annual updates. An infection control audit of the practice to check compliance with the Department of Health Code of Practice on the Prevention and Control of Infections and Related Guidance 2010, had been carried out in August 2014 by the clinical commissioning group (CCG) infection control lead. The practice was found to be overall compliant with some minor recommendations. The majority of improvements had already been implemented, for example, the introduction of hand hygiene posters and regular update training for staff.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Staff, for example reception staff, who were not protected against hepatitis B, were not expected to clean any body fluid spillages. This was supported by what we observed during our visit.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Requires improvement

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella risk assessment had been carried a few days prior to our visit. We saw recommendations had been made to reduce the risk of legionella and the practice had a plan to implement these measures.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw the practice had a contract in place with a supplier for the annual service of medical equipment, for example, weighing scales and the spirometer.

Following a vandalism incident several years earlier, CCTV had been introduced in public areas to improve security levels for staff and patients.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, our review of five staff files found no evidence of references in two files and no proof of identity or a recent photograph in any file. We also found DBS checks were not sought for administration and reception staff who carried out chaperone duties.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Where possible staff covered each other's annual leave or other absence. When GP locums were required they were booked as far in advance as possible and were known to the practice.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw notes of practice meetings where staffing levels and skill mix were regularly discussed to meet the demands of the service.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy in place which was under review. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that risks were discussed at GP partners' meetings with the provider and within team meetings. For example, we saw issues relating to staffing and the premises had been discussed at a recent meeting.

The practice manager conducted a 'daily walk about' of the premises to monitor the environment for risks. Infrequent formal risk assessments were carried out, for example we saw a security risk assessment undertaken in May 2014 and the one prior to that was dated 2008.

The practice had a large proportion of patients under the age of nine years and prioritised rapid access for children under the age of 14 years to respond to sudden changes in their condition.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A disaster recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. For example, electric failure, loss of IT and

incapacity of staff. The document also contained relevant contact details for staff to refer to. For example, supplier and relevant staff contact details; the plan was regularly reviewed to ensure it was up to date.

Records showed that staff were up to date with fire training and that they practised regular fire drills. Fire equipment and alarms were regularly checked to ensure they were working effectively.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw notes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist areas such as sexual health and family planning. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support through daily informal meetings for GPs and nurses.

We saw data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

The practice participated in peer review and was found to have above average referrals for obstetrics and paediatric accident and emergency admissions. This was due to the high proportion of patients in these population groups.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The CQC GP special advisor saw a number of examples where patient records had been coded to alert staff, for example, housebound patients and vulnerable patients.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice showed us two clinical audits that had been undertaken in the last 12 months. Both of these audits were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the close monitoring of high risk drugs such as methotrexate, which is used to treat conditions where some kind of 'over-activity' in the body is causing problems. The other audit also involved a medicine following a safety alert and showed the actions the GPs. The re-audit showed sustained improvements in prescribing of this medicine.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 93% of patients with diabetes had an annual medication review, and the practice achieved 91.1% in the clinical domain of QOF and 93.6% overall. Both were slightly below the CCG average. QOF data indicated the number of diabetic patients who had a blood pressure reading in the last 12 months was lower than expected; the practice was aware of this and was expecting this to improve when the practice offered extended hours to improve access for the working age population in the next year.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Reception staff had access to a reference list of conditions to identify urgent need. For example, coughs and cold were triaged as urgent for the nurse and a cough of long duration or coughing blood was triaged as urgent for the GP.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine

health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. A prescribing decision support system was in place to encourage cost effective prescribing. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

Effective staffing

The practice had invested in an online training resource which provided an individual e-learning training package for staff dependant on their role. We reviewed a sample of staff training records and saw that staff were up to date with attending mandatory courses or it was scheduled to take place in the next month, such as basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, two nurses had been supported, one to gain their prescriber qualification and another had successfully completed their return to practice course. The practice had recently achieved accreditation as a training practice, although no trainee was yet in post.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. The nurse with extended role in asthma also received appropriate training to fulfil this role.

We were provided an example of where a staff member's poor performance had been identified and appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the risk register. These meetings were attended by district nurses, social workers, and palliative care nurses as appropriate. Decisions about care planning were documented in the patients' records and meeting notes.

The practice worked with the community midwife to provide antenatal and postnatal care for patients. We spoke with the midwife who confirmed the good liaison they had with the GPs.

The GPs and nurses had met with the community mental health consultant in July 2014 to obtain a better understanding of the role of the adult community mental health team. This facilitated better communication and working to meet the needs of patients with mental health conditions. Regular six monthly meetings to facilitate effective working were planned.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made all referrals where possible through the Choose and Book system, except for the children's specialist and mental health services. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (Emis Web) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw an example in one of the reported incidents where the 'do not attempt cardiopulmonary resuscitation form' had been completed after discussion with the patient and family.

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

There was a practice policy for documenting consent for specific interventions including information about Gillick competency. We saw examples of consent obtained for minor surgery and fitting of an intra-uterine contraceptive device.

Health promotion and prevention

The practice was aware of local health priorities for example, admission avoidance for children and patients with mental health conditions. The practice had online access to health questionnaires. For example, depression assessment, alcohol questionnaire and asthma review.

All new patients completed a medical questionnaire as part of the registration process with the practice; issues of concern were followed up with the GP. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by promoting child immunisation and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 84 patients in this age group took up the offer of the health check in 2013/14.

Patients with long term conditions had annual reviews, for example in 2013/14: 93% of patients with diabetes, 76% of patients with asthma, 95% of patients with chronic obstructive pulmonary disease and 100% of patients with coronary heart disease. In addition, 100% of patients with dementia had an annual review and 97% of patients with severe mental health had a review and agreed care plan in place.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. All patients had a named GP to facilitate continuity of care. The practice kept a register of all patients with a learning disability and 100% had an annual review in the last 12 months. The practice had also identified the smoking status of 90% of patients over the age of 16 and 98% had been offered smoking cessation advice.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was 85%, which was above average for the local area. 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 offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for flu was 66%, two patients we spoke with told us they had been called to encourage them to make an appointment for their 'flu jab'. Two patients we spoke with said they had been informed about the immunisations for their children including the flu vaccine. Childhood immunisation was above the CCG average for 12 months (over 99%) and five years. Although, MMR uptake at 24 months was slightly below the CCG average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey based on 92 (31%) survey responses showed the practice was rated above or very close to the local average for all the areas. The practice scored highly on satisfaction of patients calling the practice and obtaining appointments (94% and 90% respectively). We also saw the practice was rated above the local average for the number of patients who recommended the surgery (88%) and 91% of patients described their overall experience as good. The practice was also rated highly for GPs giving patients enough time, explaining tests and listening to them.

During the inspection on 4 December 2014 we spoke with 12 patients, all of whom had family members who also attended the practice. The patients had been with the practice varying times from a few months to over five years. Eight patients were in the working age group, some with young children and four were older patients. All the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Everyone praised the staff; they mentioned the helpfulness of reception staff to accommodate them for appointments and the compassion shown by the GPs during the consultation.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards and the majority were positive about the service experienced. All of the comments except one were very positive about all aspects of the service provided. The one negative comment was brought to the attention of the practice and they were aware of the incident and in the process of investigating it.

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

During the inspection we witnessed a number of caring and discreet interactions between staff and patients to preserve their dignity and privacy. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. We saw the reception area was open and did not facilitate private conversations at the desk. However, a TV in the waiting room provided some background noise and distraction for waiting patients and reduced the risk of conversations at the reception desk being overheard. The national patient survey reported 74% of patients were satisfied with the level of privacy, although 65% of these patients said that other patients could overhear but they did not mind.

Care planning and involvement in decisions about care and treatment

The patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. Data from the national patient survey showed the practice performed slightly less well in GPs involving patients in care decisions and explaining treatment and results. However, this was accounted for by the fact over 10% patients said the question did not apply to them.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw information on the practice website informing patients about this service.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we

Good

Are services caring?

spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. One patient we spoke with who had suffered bereavement said they had appreciated the support provided by the practice at the time.

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

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had developed and increased its practice list size by approximately 1000 each year for the last two years. The practice was aware of its increasing population and the changing demographics, for example, young mothers and homeless people.

The practice engaged with its practice forum members to obtain their views. However, no survey had been conducted. The main areas of discussion with the patient forum was the relocation of the practice to its new site and the plan for extended opening hours as the list size continued to increase.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. An equality and diversity policy was in place. Staff were aware of the needs of different population groups and had tried various initiatives to develop services to meet their needs. For example, an open access clinic for children and an on-site counsellor for patients with mental health conditions.

The practice had access to online and telephone translation services. Although, staff said the need rarely arose.

The temporary portacabin premises had been adapted to meet the needs of people with disabilities, for example, patient areas were all on the ground floor to accommodate wheelchair users. However, the lack of automatic entrance door made it difficult for patients in wheelchairs and parents with prams/pushchairs to enter the premises.

We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

One of the GPs had carried out an educational session for mothers to inform them how to self-treat and what to look out for in their children to promote appropriate attendance and reduce admission to A&E.

Access to the service

The practice offered a relatively large number of same day appointments to cope with the demand of its younger patient group. Appointments were available from 8.30am to 6pm on weekdays, except Wednesdays when the practice closed at 1pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed including on Wednesdays when the practice closed at 1pm. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The practice used a code for patients who were housebound to alert them to the need for a home visit. All patients under the age of 14 years were offered a same day appointment.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. However, non-urgent appointments often required a two week wait. The national patient survey reported the practice performed less well on patients waiting more than 15 minutes after their appointment time to be seen. However, most patients we spoke with on the day of inspection said they normally waited less than 15 minutes.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

(for example, to feedback?)

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

We looked at six complaints received between April 2013 to March 2014, which had been reviewed at a clinical meeting in May 2014. We found these were all satisfactorily handled and dealt with in a timely manner. The complaints were analysed for themes for example, GPs were reminded to clearly mark urgent requests as urgent. Notes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

We saw that information was available to help patients understand the complaints system on the practice website and leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

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 was owned by a private company, BK Health Limited. Three of the GPs at Berryfields Medical Centre had originally been salaried doctors and became salaried partners in 2014. The GPs and practice manager met with one of the company directors monthly to discuss the practice performance and development. The practice had a mission statement which was 'To provide high quality health care from a friendly dynamic team'.

The practice had a one year business plan in place which was regularly reviewed and monitored at team meetings.

We spoke with 11 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Some staff had been with the practice since its inception and felt a strong loyalty towards it. All staff were involved in the planning for the new premises and its future development.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding and clinical governance, another GP was the human resource lead and the third GP was lead for QOF. All the staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used a document management system to update policies and procedures. All staff accessed policies and procedures on the practice intranet. The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at seven of these policies, all of which had been reviewed in the last year. A clinical induction pack was in place for locums which included all the practice operational policies and procedures for ease of access.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits of high risk drugs.

The practice had arrangements for identifying, recording and managing risks. However, regular formal risk assessments were not carried out. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a security risk assessment undertaken in May 2014 and the one prior to that was dated 2008, when there had been a vandalism incident.

The practice held monthly practice meetings which included governance issues. We looked at notes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from notes that team meetings were held regularly, at least monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

Staff had access to the electronic staff handbook that was available to all staff. This included a range of policies including on annual leave, disciplinary, grievance and bullying and harassment. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through complaints and comments. The practice had very recently introduced the NHS 'Friends and Family test' which was accessible in the practice and via the website. However, results were not available yet.

The practice had a patient participation group (PPG) or patient forum which had ten members; there was a much larger virtual group of 300 patients. We spoke with two representatives of the patient forum. They told us the forum met with the practice once or twice a year. At a recent meeting the main areas of discussion had been the development of the practice to meet the growing list size. Patients were also concerned about the relocation of the practice to its new site and the impact this would have on patients, for example, transport arrangements.

Are services well-led?

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

Staff felt valued and supported. Some staff had been with the practice from the start and all felt ownership and loyalty to the practice. Staff had also been involved in the planning of the new premises. Regular staff meetings were held and six monthly team building events. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. All staff had regular appraisals to review performance and identify training needs in line with the practice development. For example, the practice had supported one of the GPs to become a GP trainer and continued to support its nursing staff to develop their skills.

The annual schedule of meetings included learning sessions for all staff such as safeguarding. The practice also held weekly clinical teaching sessions.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and to ensure the practice improved outcomes for patients.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered provider did not ensure that the all the information specified in Schedule 3 was available. Regulation 21 (b).**