Branch End Surgery

Quality Report

Branch End,
Stocksfield,
Northumberland,
NE43 7LL
Tel: 01661 842626
Website: www.branchendsurgery.co.uk

Date of inspection visit: 21 October 2014
Date of publication: 22/01/2015

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 this comprehensive inspection on 21 October 2014, and visited the location of Branch End, Stocksfield. The practice provides a Primary Medical Services contract (PMS) to approximately 5,500 patients from Stocksfield and surrounding areas, which are predominantly rural.

Overall, this practice was rated as good.

Our key findings were as follows:

- Patients reported good access to the surgery and told us they did not have particular problems in obtaining appointments.
- Patients reported the practice provided a caring service, where people were treated with dignity and respect. The practice was highly valued locally.
- The practice held regular multi-disciplinary care meetings to ensure good care was provided.
- The practice had strong clinical audit and incident reporting systems.
- There was a strong stable team, providing good peer support to staff members.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Implement a system of stock control, date checks and point of use checks to ensure that all single use clinical instruments stored and used are within their 'use by' dates.
- Dispose in accordance with the appropriate guidance any unused instruments or equipment which have expired.
- Improve cleaning schedules, infection control auditing and risk assessment, in order to demonstrate compliance with infection control guidance.

In addition the provider should:

- Ensure all staff are brought up to date with their yearly appraisals.
- Review and if necessary update policies and procedures on a regular basis, and record these review dates.
- Devise a system which allows the practice to have an overview of all staff essential training and the required dates for refresher training.

Summary of findings

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 requires improvement to ensure it provides a safe service. While we found that staff understood their responsibilities with respect to raising concerns, identifying incidents and communicating lessons learned from these, there were shortfalls with respect to ensuring all equipment and medicines were within date, and all efforts had been taken to minimise the risk of infection transference.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Best practice clinical guidance was referenced and used routinely. People's needs were assessed and care was planned and considered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff worked well with other health and social care professionals. Clinical staff had received training appropriate to their roles and could ask for further training, although not all staff were up to date with appraisals so not all staff had personal development plans.

Are services caring?

Good

The practice is rated as good for caring. Patient surveys showed high levels of satisfaction. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. We saw that staff treated patients with kindness and respect and ensured confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day, it was however more difficult to request a specific named GP. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and strategy, and was developing a strategy for succession

Summary of findings

planning. 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. The practice had a number of policies and procedures in relation to the running of the practice. Some of these were overdue for review, however the practice had identified this and was carrying out a large scale review of their procedures and how they could improve.

The practice proactively sought feedback from patients and had an active virtual patient participation group (PPG). All staff had received inductions and attended staff meetings and events.

Summary of findings

What people who use the service say

In the practice patient participation survey carried out in February 2013, 193 patients responded. Ninety seven per cent of patients described their experience of the practice as good, very good or excellent, while 96% of patients said they would recommend the practice to someone who had just moved to the local area. Ninety per cent of patients said that the practice was open at times that were convenient for them. In all areas the practice scored higher than the national benchmarks.

In the 2013 national GP Patient Survey of 126 people, 85.4% of people said they would recommend the practice, 86.3% of people gave a positive answer to how easy it was to get through to the surgery by phone, and 89.5% of people rated their experience as good or very good, these results being the same or above the national average.

We spoke with seven patients on the day of inspection, and also collected 29 CQC comment cards, which patients filled in prior to or during the inspection. General themes in the feedback were that patients were satisfied with their care, and they found the practice to be caring and friendly. Patients told us they were treated with dignity and respect, that clinicians took sufficient time in examinations and they explained results. Areas people were less satisfied with included telephone access to the surgery over lunch-time, and sometimes people had a longer wait to get an appointment with the GP of their choice.

Areas for improvement

Action the service MUST take to improve

- Implement a system of stock control, date checks and point of use checks to ensure that all single use clinical instruments stored and used are within their 'use by' dates.
- Dispose in accordance with the appropriate guidance any unused instruments or equipment which have expired.
- Improve cleaning schedules, infection control auditing and risk assessment, in order to demonstrate compliance with infection control guidance.

Action the service SHOULD take to improve

- Ensure all staff are brought up to date with their yearly appraisals.
- Review and if necessary update policies and procedures on a regular basis, and record these review dates.
- Devise a system which allows the practice to have an overview of all staff essential training and the required dates for refresher training.

Branch End Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a second CQC inspector, and a Practice Manager.

Background to Branch End Surgery

Branch End Surgery is located in a converted and extended residential property over three floors, and comprises six consulting rooms, two treatment rooms, and two patient waiting areas. There is also a Baby Clinic room. There is no lift; however three consulting rooms and a treatment room are located on the ground floor. There is a dedicated disabled parking space.

The practice provides a Primary Medical Services contract (PMS) to approximately 5,500 patients from Stocksfield and the surrounding area, which is predominantly rural. There are five GPs, of whom two are partners and three are salaried. The practice is a training practice and had two GP registrars in training (qualified doctors who wish to gain experience in General Practice).

Patients can choose to see either a male or female GP. There are also three practice nurses, a phlebotomist, dispensing staff and a team of administrative and management staff. A psychotherapist also attends the surgery six hours per week.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury.

The practice is located in the Clinical Commissioning Group (CCG) area of Northumberland. In common with the CCG area overall the practice's patient list has a high proportion of people aged over 65 years and correspondingly a lower proportion of people of working age or younger families, The CCG area also has higher than average levels of people with long term health conditions such as heart disease, stroke and dementia. There are also higher than average numbers of those with carers' responsibilities, and those claiming disability allowances.

The practice has opted out of providing out of hours services to their patients, this is provided by Northern Doctors Urgent Care. When the practice is closed patients access 111 and for emergencies they contact 999. The practice is open from 8am until 6pm Monday to Friday, with an earlier start of 7am on Tuesdays in order to enable patients who have work responsibilities to attend appointments.

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. The practice was inspected at random from the CCG area.

Detailed findings

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

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed information the practice provided before the inspection.

We carried out an announced inspection on 21 October 2014.

We reviewed all areas of Branch End Surgery including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GPs, nurses and other clinical staff, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hours team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents and processes used by the practice to run the service, and observed how these worked in practice.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety, including reported significant events, national patient safety alerts, and comments or complaints received from patients.

Prior to inspection the practice gave us a summary of 14 significant events from the period October 2013 - October 2014, and six complaints from the same period which had been investigated and learning points disseminated at team meetings.

The records showed that staff reported incidents, including safeguarding concerns and errors in referral processes. Staff we spoke to were aware of the incident policy and how to access this, and were aware of their responsibilities to raise concerns. Incidents were discussed and learning/ action points raised as a result. Where necessary the practice had flagged up events via an electronic monitoring system which enabled GP practices to log incidents centrally at the CCG.

GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development.

From our discussions we found that GPs and nurses were aware of the latest best practice guidelines, and these had been discussed at clinical meetings and incorporated into day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. We found that the practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents that were occurring, and could evidence a safe track record over time.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. The practice worked with the Clinical Commissioning Group (CCG) in reporting any incidents of poor performance.

Records were kept for significant events, and these were provided to us from the past year. We saw where incidents had been discussed and reviewed, and the information then shared across the practice as learning points at monthly practice meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to the relevant staff. Staff members said they were encouraged to report incidents and felt confident doing so. Any member of staff could report an incident and these were then collated by the practice manager.

National patient safety alerts were communicated via email to practice staff. Staff were able to show examples of recent alerts and the actions they had taken as a result. We saw that alerts were also discussed at clinical team meetings, to ensure that staff were aware of any relevant to the practice and where action needed to be taken.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had child protection and vulnerable adult policies in place which were last reviewed in January 2013. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff could also access links to Local Authority safeguarding teams through their computer system, and contact details were displayed in the practice. Staff were able to describe types of abuse and how to report these.

The practice had named GP adult and child safeguarding leads, which staff were able to identify. Clinical staff had been trained in safeguarding to a level appropriate to their role, and training for administrative staff had been arranged for October 2014.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on the practice computer system, which collated all communications about the patient, including scanned copies of communications from hospitals. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were

aware of any relevant issues when patients attended appointments; and we saw examples of this, for instance children subject to child protection plans or where domestic violence may be present.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were on child protection plans were clearly flagged and reviewed. These were discussed at monthly practice meetings and any actions required agreed. GPs were able to discuss instances where they had participated in multi-agency involvement in safeguarding concerns.

The practice had a chaperone policy; however this had been due for review in October 2013. There was information on this service for patients in reception. A mixture of clinical and non-clinical staff had been given chaperone training, and understood their roles and responsibilities in relation to this.

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. We checked medicines stored in the fridges and found these were stored appropriately. Appropriate checks took place to make sure refrigerated medicines were kept at the correct temperature.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. We saw records showing all members of staff involved in the dispensing process had received appropriate training. Each dispenser checked expiry dates before assembling a prescription

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. For refrigerated medicines such as vaccines, each nurse was responsible for ordering and recording the number used that day.

Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a medicines manager and prescribing lead who continually audited prescribing trends, such as an increase in prescribing of antibiotics or hypnotics. These were discussed and analysed at regular practice meetings and also with the CCG.

We saw evidence that the doctors bags were regularly checked to ensure that the contents were intact and in date. Emergency medicines were available and all staff knew where they were kept in the practice.

Prescriptions pads were stored securely, and there was a system in place to double check repeat prescriptions before they were generated. Any errors were logged as incidents and investigated. There were safe systems in place for the dispensing of prescriptions, such as a second check by another dispenser and identification checks for controlled drugs prescriptions. GPs viewed and signed prescriptions before they were given to the patient.

Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of recent guidance around end of life care and what action had been taken. The computer system identified drug interactions for patients with multiple conditions, and allergies to medicines were documented. This ensured staff were aware of any changes and patients received the best treatment for their condition. GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. Systems had been developed for some patients to have more frequent reviews or to have monitoring tests such as blood tests taken before certain high risk medicines or controlled drugs could be repeat prescribed.

Cleanliness & Infection Control

We observed all areas of the practice to be clean. Patient toilets were observed to be clean and had supplies of hot water, soap, paper towels and hand sanitizer. Aprons,

gloves and other personal protective equipment (PPE) for staff were available in all treatment areas. Sharps bins were appropriately located, labelled, closed and stored after use.

The practice had an infection prevention and control (IPC) policy dated September 2012, and waste disposal and legionella testing policies. There was an identified Infection Control GP lead. We saw evidence that legionella testing was carried out in line with the policy. We saw evidence that clinical staff had training in IPC, although cleaning and other staff had not received recent training.

There was a basic cleaning schedule for cleaners which detailed daily and monthly tasks. The practice manager stated they had taken the privacy curtains from consulting rooms home to wash periodically, but no record was kept of this, or whether the curtains had been washed in accordance with infection control guidance, for instance at the required temperature. Whilst consulting room carpets appeared to be visually clean, no cleaning records were kept of this, and there was no documented schedule for carpet cleaning.

No regular infection control audits had been completed. There was some informal monitoring but this was not recorded. The practice manager had identified this as an issue and recently carried out a preventative maintenance survey of the building, which had identified some minor issues such as the disrepair to flooring and a split in the covering of an examination couch. These had been identified as actions and the practice manager was sourcing repairs or replacements

Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. GPs told us they were responsible for checking their own disposable equipment in their consultation rooms. However in each room we checked we found large quantities of out of date equipment, including hypodermic needles expired in 2008, lubricating jelly from 2011, and vaginal speculums which had expired in 2010. It was therefore no longer possible to know whether these instruments and equipment were sterile at the point of use, and therefore could pose an infection risk.

We also observed reception staff receiving urine samples from patients over the counter without wearing gloves.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. There were procedures in place to ensure that equipment was checked, calibrated and functioning correctly. Staff were trained and knowledgeable in the use of equipment for their daily jobs. Items of medical equipment were on service maintenance contracts where necessary, to ensure their speedy repair or replacement. Contracts were in place for annual checks of equipment such as fire extinguishers, the defibrillator, spirometer and 'portable appliance testing' for electrical items. Review dates for these were overseen by management staff who set reminders for when maintenance was due.

Staffing & Recruitment

There were arrangements in place for members of staff, including GPs, nursing and administrative staff to cover each other's leave. The senior partner reported there was generally a sufficient pool of staff to cover eventualities, and they rarely had to use locums. If locums were occasionally used the practice recruited from a known firm and tried to use locums familiar with the practice. Two staff had recently been recruited, and for the most part the staff team was longstanding.

We saw two instances in staff files for recently recruited members of staff where interview checklists and Disclosure and Barring Service (criminal records) checks had been carried out, but there was no evidence that the practice had followed up references from previous employers, despite this being stated as a requirement in the practice interview and recruitment policy. The practice manager stated references would be followed up in the future.

The practice had recently had a meeting involving all team members in response to changing demand; from this an action plan had been produced to look at rotas, roles, skill mix and holidays. Some roles had been adjusted slightly, and staff confirmed the practice now worked much better together as a team. We saw there was a rota system in place for all the different staff groups to ensure they was enough staff on duty to meet the needs of patients.

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and

were able to respond appropriately. The Practice had systems for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks of the building, the environment and equipment, so patients using the service were not exposed to undue risk.

Patients with a change in their condition or new diagnoses were discussed at the weekly practice clinical meetings, which allowed clinicians to monitor treatment and adjust it according to risk. GPs often discussed cases on a daily basis to monitor a sudden or deteriorating condition. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example for patients with long term conditions there were emergency processes in place around handovers to other GPs and out of hours service. Staff gave us examples of referrals made for patients that had a sudden deterioration in health, and we saw examples of an emergency health care plan. The practice monitored repeat prescribing for patients receiving medication for mental health needs throughout the practice area, such as prescribing of hypnotic medication for patients in care homes. In response to guidance, the practice had carried out a clinical audit on fever in children, and produced new templates to ensure the appropriate level of information was gathered, and also developed leaflets around the subject. Therefore the practice was positively managing risk for patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen, emergency medicines and an automated defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation.

Staff who would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experienced a cardiac arrest. Staff could readily describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose.

There was an emergency protocol easily accessible to staff, and the telephone system was able to be used as a practice-wide emergency pager system to summon help to the site of any emergency, along with panic alarms. 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 and anaphylaxis. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. A business continuity plan was in place which had been updated in May 2012. This included details of how to deal with events such as loss of computerised clinical system, staff sickness, fire and loss of utility services. There were fire procedure and evacuation plans, although we were unable to ascertain when the last fire drill had been carried out as there was no evidence to support this.

Staff were able to describe how they could increase capacity by putting on extra surgeries in response to changing demand such as flu clinics. As the practice was in a rural area the partners were equipped with either 4-wheel drive vehicles or winter tyres.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into the practice and disseminated via the computer system. Clinical staff were able to describe how they cascaded learning in the practice after attending training events, by discussing these at clinical meetings or distributing a presentation.

Treatment, assessment and investigations were considered in line with evidence based best practice, and clinical staff were able to provide examples of meetings where new guidelines and protocols were discussed. All the GPs interviewed were aware of their professional responsibilities to maintain their knowledge, and specialised in a particular interest area, for instance joint injections or sexual health, so they were able to benefit the practice as a whole with this knowledge.

Patients had their needs assessed and care planned in accordance with best practice. The staff we spoke with and evidence we reviewed confirmed this was aimed at ensuring that each patient was given support to achieve the best health outcome for them. For example patients with diabetes were having regular health checks, and were being referred to other services or discussed at multi-disciplinary meetings when required. Feedback from patients confirmed they were referred to other services or hospital when required.

Staff were able to evidence where they had discussed specific care pathways with consultant physicians and with the patient to achieve the best outcome. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Practice nurses told us they managed specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. This meant they were able to focus on specific conditions and provide patients with regular support, based on up to date information. Care was planned to meet identified needs and was reviewed regularly. Active monitoring of patient outcomes took place through specific clinical audits and the quality and outcomes framework. The practice could produce a list of patients with learning disabilities, those with long term conditions or who were in need of palliative care and support.

The practice held a rolling programme of multi-disciplinary care meetings to ensure these patient's needs assessment remained up to date, for instance one week was given over to long term conditions, one week prescribing, and at all meetings referrals were discussed. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions, with the GPs actively working towards reducing referrals in their areas of speciality. For instance one GP demonstrated how they had worked with the Clinical Commissioning Group (CCG) to develop a pathway to reduce ear, nose and throat referrals for children with glue ear through the use of tympanometry (ear examinations) in primary care.

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

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. QOF is a national performance measurement tool. Latest QOF data from 2012-2013 showed the practice performed at or above average for clinical indicators compared to the CCG area, and had an overall rating of 99.1%, which was above the England average. The data showed the practice supported patients with long term conditions such as diabetes, asthma, and chronic heart disease. Nursing staff monitored uptake of childhood immunisations and these were at or above average.

The practice had a system in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. The practice showed us a number of recent audits, covering subjects such as child fever, and prescribing of specific medicines for stroke or to lower cholesterol. The practice was able to

Good

Are services effective?

(for example, treatment is effective)

demonstrate changes resulting since initial audits as a result of re-audit to complete the audit cycle, such as discussing medication with patients and carrying out reviews for patients with chronic obstructive pulmonary disease. For other audits a future date was included for re-audit to so the practice would be able to identify if the changes had led to improvements in care

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

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. Clinical staff also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of 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 worked with the CCG as requested to assess clinical outcomes for the local area relative to other practices and the CCG area. The practice was able to give examples of how they had disseminated good practice through a local practice manager's meeting around prescribing or a particular medicine, and also participated in a regional COPD audit.

Effective staffing

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The practice was a training practice and provided protected learning time for this, with GPs attending a training session one evening per month. There was a good skill mix among the GPs, who specialised in areas such as joint injections, minor surgery or sexual health, and they were able to lead on these areas.

The practice stated they had recognised that training for administrative staff was lacking, and had sourced information governance and equality & diversity training, and this was scheduled. Administrative staff had recently received child safeguarding training and basic life support training.

On starting, staff commenced an induction programme that covered the practice's health and safety, policy and procedures, confidentiality and the computer system Staff did say they felt well supported, worked well as a team and could approach their managers if they were unsure of anything. Reception and dispensing staff had undergone a 'mini-appraisal' in September 2013, in response to some widespread dissatisfaction and management issues. These had addressed some of the problems staff had reported, and staff reported they now felt a lot happier in their roles. The finance manager and reception manager had not been appraised since 2009 and 2011 respectively. Staff told us they would like to be formally appraised on an ongoing basis, where they could discuss objectives and identify learning needs.

Nurses were responsible for their own Continuing Professional Development and discussed subjects they had covered and audits carried out as part of this. Records were given to the practice manager each year. Nurses told us they were supported in accessing additional specialist training pertinent to their role, such as attending a sexual health training course.

Nursing staff held regular clinical supervision and discussion meetings with the GPs. There were no regular supervision sessions on a one to one basis for all staff members, although staff did say they felt confident in raising concerns or issues.

Good

Are services effective?

(for example, treatment is effective)

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

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. For example regular meetings were held with community nurses to discuss the needs of those requiring palliative care, or those who would require it and joint visits were held with the community nursing team. Multi- disciplinary meetings at the practice for high risk or end of life care patients had involved palliative care consultants, Macmillan nurses and social workers. GPs and nurses within the practice worked closely together. We saw the practice was piloting a new system of working with consultant dermatologists, which involved emailing a photograph of a patient's condition, helping avoid the need for a full referral and speeding up diagnosis time for the patient.

The service used special patient notes, care plans and do not attempt resuscitation requests, which were updated and reviewed to ensure out of hours providers had accurate information available to them.

Information from out of hour's services was disseminated by reception staff to the appropriate GP who checked as a first task each morning, and arranged follow up treatment or appointments where required.

The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness.

Blood results, investigations and information from out of hour's providers were generally received electronically and disseminated straight to the relevant doctor or nurse, or their covering colleague in the case of absence. Where necessary a procedure for scanning documents such as discharge letters was in place. The GP seeing these documents and results was responsible for the action required. The GP recorded their actions around results and discharge on the computer system or arranged to see the patient as clinically necessary.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner through the use of special patient notes and admission avoidance care plans. There were weekly practice meeting where patients were discussed, and a monthly practice meeting for all staff.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were trained on the system, and commented positively about the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

For patients requiring a two week referral the GPs filled in the referral forms straight after the consultation, while all routine referrals were completed within seven days. GPs told us they could ring or email hospital consultants to discuss urgent appointments. Referral letters and results were generally received electronically or scanned and then sent directly to the relevant GP. GPs told us they had a productive relationship with local hospitals, and that information sharing had improved.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling the requirements of these. 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, by describing specific examples around being involved in best interest decision meetings and assessment of capacity on an ongoing basis. We saw examples of care plans where best interest decisions and actions had been documented, with patient input and preferences where possible.

We saw examples of where those with a learning disability or other mental health problems were supported to make decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to assess children aged under 16 with respect to their capacity to consent to medical examination and treatment).Verbal consent was documented on the

Good

Are services effective?

(for example, treatment is effective)

computer as part of a consultation. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice offered all new patients a consultation to assess their past medical history, care needs and assessment of risk. The needs of new patients were assessed and a plan of the person's ongoing needs to stay healthy was developed. Advice was given on smoking cessation, alcohol consumption and weight management. The practice also offered dementia screening and participated in initiatives such as the bowel cancer screening campaign, and flu vaccinations clinics were carried out each year, including holding sessions in the community to make it easier for elderly or otherwise vulnerable patients to attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance, and was a designated yellow fever centre. The practice kept a register of all patients with learning disabilities and all were offered an annual physical health check.

Patients could access antenatal care and baby clinics via the midwife or nurses in a dedicated room at the practice. GPs provided a full range of contraceptive services including emergency contraception, while nurses were able to provide more general contraceptive advice. A weekly Child Health Clinic was run by the health visitor and doctor, and a separate weekly clinic was held for routine immunisations and advice on health care. There were procedures for following up children who did not attend for immunisations by the named practice nurse, who could also liaise with health visitors and GPs regarding any possible safeguarding concerns. QOF data from 2012-13 showed performance for all immunisations in the practice was above the CCG average.

The practice was a research practice and had been involved in studies to identify patients at risk of liver disease, and helping patients manage hypertension by looking at lifestyle intervention to lower blood pressure. The practice had an in-house psychotherapist six hours a week, and could also refer to external services. This supported patients with mental health issues with the promotion of their mental health and well-being.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent patient survey data available for the practice. The 2012-13 NHS England GP patient survey showed that 89.5% of patients described their overall experience as fairly good or very good, and 91.9% said the doctor was good or very good at treating them with care and concern. Both these figures were above the national average. The practice patient survey for 2013 had responses from 193 patients and 97% said their overall experience was good or very good, with 96% of patients saying they would recommend the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 28 completed cards, and also spoke with seven patients during the inspection. The majority of these were positive about the service experienced, with people describing the staff as respectful, caring and friendly. People said they were listened to by the doctors and felt involved in their care. Many people highlighted examples of where they felt they had received particularly good care, and many patients had stayed with the practice for a number of years.

Of less positive comments received, the commonest theme was people having to wait to see the doctor of their choice. This was reflected in the practice patient survey, with only 25% of people saying they always or almost always saw the doctor of their choice, and 50% of patients saying this in the 2013 national patient survey. The practice was aware of this and tried to schedule reviews so patients could be seen by the same doctor, or ensure good handover information was available. Patients were able to see a GP quickly for urgent or emergency appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice phones were located away from the reception desk and were shielded by glass partitions which helped keep patient information private. Background music was played in reception, which patients said helped improve privacy, and patients were offered the facility to speak to a receptionist in a private room if required. This was advertised on a poster.

Care planning and involvement in decisions about care and treatment

Patients we spoke to during 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 confirmed patients felt listened to and involved in their care.

The NHS England GP patient survey results for the practice reported that 91% of people said they were involved in decisions about their care. The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care, and nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment. The surgery offered longer appointments to those with more complex conditions to allow the patient extra time to discuss their care and treatment. Patients were encouraged to take an active role in managing their conditions, for instance diabetics were sent their result letters prior to their review appointments, so they had time to think about what issues they wanted to raise before their review appointments.

Patients were encouraged to bring relatives, friends or advocates with them if they felt they needed some help in making decisions about their care.

People said the GPs explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us there was a translation service available for those whose first language was not English, and we saw details for this service.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support services

Good

Are services caring?

to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service, and some highlighted when they had been given additional care and support following bereavement.

The practice was signposting patients and/or families to local bereavement counselling services when necessary, and also contacted patients either by telephone or home visit following bereavement to ensure they were supported.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. The practice's computer system alerted staff if a patient was also identified as being a carer so they could opportunistically assess whether the person needed extra support. The practice website signposted people to the mental health charity MIND, and contained copies of leaflets specifically aimed at young people, such as sexual health, anorexia and drug use.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities. Longer appointments could be made available for those with complex needs and there was a chaperone policy available.

The practice engaged with the CCG and had been involved in local initiatives to reflect patient need, such as sexual health screening and physiotherapy referral pilots.

The practice and GPs were long standing and well established in the area, so had a good understanding of the local population and their specific needs, and this enabled good continuity of care. Patients were offered regular review where possible with the same named GP or nurse. Longer appointments were available for people who needed them and those with long term conditions, and telephone appointments or home visits where required.

The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Tackling inequity and promoting equality

The practice was in a converted building and rooms were located over three floors. There were some steep stairs internally, however downstairs rooms were available for those with mobility issues. There was appropriate access into the building for people with mobility issues, an access enabled toilet and one disabled parking space. Staff explained they either knew the patients' needs or asked them to ensure the right room was allocated which they could access. The practice had a register for patients who may be vulnerable, such as those who were elderly and frail or with mental health difficulties and these patients were discussed regularly at clinical meetings to ensure the practice could meet their needs.

There was a practice information leaflet available in reception. There were no leaflets available in large print or other languages, although the practice had carried out an analysis of their ethnic profile and had not identified a need for these. If needed patients were able to request them specifically. There was a hearing loop at reception for those with a hearing difficulty. The practice had a recently updated equality and diversity policy, and training in this subject for administrative staff was due to take place.

Access to the service

Patients could telephone the surgery to make appointments, and they could also book appointments online through the practice website. Repeat prescriptions could also be ordered online or by telephone. The practice had extended opening hours in response to patient feedback, and was open from 7am until 6pm on Tuesdays and 8am until 6pm the rest of the week. The practice was closed on weekends. The early morning surgery was to make the service more available to working people and those with young children, although the appointments could be utilised by anyone.

Opening times and closures were advertised on the practice website, with an explanation of what services were available. Longer appointments for multiple conditions were available. A small number of appointments were blocked out each day for patients who needed to be seen urgently. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving instructions on how to contact the Out of Hours service. This information was also available on the website.

Feedback from patients confirmed they 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. Patients did say there was sometimes a long wait to see a specific GP. Patients who were vulnerable, for instance children with learning disabilities, were identified on the computer system via special patient notes, so they could be accommodated and given fast access to a GP or nurse. Some changes had been made to the appointment system as a result of feedback from the patient participation group. The practice had also introduced online repeat prescribing as a result of patient feedback.

Two week referrals were faxed to secondary care organisations the same day, with routine referrals discussed each week or sooner if a need was identified.

Good

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. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

The practice carried out a patient survey using an external organisation in 2013. An action plan was then drawn up and discussed with the PPG to look at the lowest results. Results of this survey were advertised on the website and via patient posters in reception. Information on how to make a complaint was available in the practice leaflet.

We looked at six complaints from the period October 2013-October 2014, and could see that these had been responded to with a full explanation and apology where necessary, and action points for learning detailed, for instance a change in procedure to deal with incoming faxes. Details of how to make a complaint were in the practice leaflet, although this did not detail contact details for NHS England or the ombudsman.

Staff described how complaints and incidents were discussed at meetings, and learning was encouraged within a 'no-blame' culture.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had patient and practice charters, which were advertised on their website and set out how they intended to provide good care. The practice aims and objectives were contained with their statement of purpose, which included reference to dignity and respect as priorities. Progress on some of these objectives could then be measured through patient surveys.

Staff we spoke to understood the values and ethos of the surgery, and a yearly practice away day was held for training, updates, and to help embed cultural values. The practice had identified areas where they wanted to improve, such as bringing all non-clinical staff up to date with training, bringing all staff up to date with appraisals, and restarting meetings for the patient reference group.

Governance Arrangements

The practice was able to demonstrate that they had recently restructured management and some roles at the surgery in response to low staff morale and following meetings with staff. This included the appointment of a new practice manager from existing staff. Staff reported they now felt a lot happier and more settled in their roles, and had a clearer understanding of what they were accountable for, and who to report to.

The practice used the Quality and Outcomes Framework (QOF) to measure their 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 a number of policies and procedures in place to govern activity and these were available to staff via the computer. However not all of these had been reviewed regularly, for instance the most up to date complaints policy we could find was 2009, the whistleblowing policy was last reviewed in 2011, and the stress policy in 2011. The majority of policies had been reviewed in 2012, and the health and safety policy in 2014. The practice manager was aware of this as an issue, and was working with the management team and senior partners to undertake a wholesale review and update of all practice policies and procedures.

There were some systems in place to assess aspects of quality and performance, for instance through clinical audits, the results and referral systems, and equipment checks.

Not all risks had been identified and managed, for instance the practice had a standard principles of infection control document from September 2012, but had not developed a specific infection control policy pertaining to the practice, and had not carried out sufficient assessment to identify all infection control risks and produce action plans for these.

Recent staff had not been recruited in accordance with the practice's own policy, which stated that references would be followed up. We found two instances where this had not happened. Therefore across the practice there were not sufficient robust arrangements to identify record and manage risk.

Leadership, openness and transparency

The GP partners were long standing at the practice and had formed a cohesive team, able to support GP registrars and medical students. Work was ongoing to develop a clear succession plan.

Staff told us they felt well supported and could approach any colleague to ask for advice. Staff described how the practice manager kept them up to date via email with updates and news. Staff described the culture as open and honest and said they generally felt able to raise issues or concerns. Team meetings were held monthly and there was an annual away day.

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

The practice had gathered patient views through surveys, complaints received, and a virtual patient reference group, who received emailed communications. There was ongoing work to recruit more people to this group, and also to restart group meetings.

Patient survey reports and action plans were published on the practice website for the practice population to read. The practice had a virtual Patient Participation Group (PPG) who were able to feed into action plans for future improvements. The practice was able to demonstrate through these action plans where they had made changes in response to feedback from the patient group and patient surveys, such as advertising online booking facilities more and introducing electronic repeat prescribing.

Are services well-led?

Good

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

Staff reported they could feedback through staff meetings or informally, although those staff not up to date with their annual appraisals did say they wanted to be appraised, as they saw this as a valuable way to discuss issues and give feedback. Arrangements to bring all staff up to date were ongoing.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring, and said they were able to ask for and access additional specialist training. The practice was a GP training practice and was supporting a medical student and two GP registrars at the time of the inspection.

Not all staff were up to date with appraisals, including the nursing staff who had not been appraised since 2012, and the finance manager since 2009. These staff said they valued the appraisal process. Nurses took ownership of their own continuing professional development and emailed the practice manager copies of certificates.

The practice had completed reviews of significant events and other incidents and shared learning from these with staff via meetings and away days 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use services were not protected against the risks associated with health care associated infection as there were not appropriate risk assessment and audit systems in place in relation to the maintenance of appropriate standards of hygiene for the premises, equipment, and materials to be used in the treatment of service users 2 (c) i,ii,iii