Beech Tree Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 9 December 2014.

Overall, we rated this practice as good.

Our key findings were as follows:

- The practice provided a good standard of care, led by current best practice guidelines.
- People told us they were treated with dignity and respect.
- The practice worked well with other providers, especially around end of life care.
- The practice performed well in the management of long term conditions.
- The building was clean, and the risk of infection was kept to a minimum by systems such as the use of disposable sterile instruments.
- The practice offered a variety of pre-booked appointments, 'sit and wait' clinics and extended opening hours.

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

The provider should:

- Identify through risk assessment all staff positions which would benefit from safeguarding training and implement this at a level appropriate to the role.
- Ensure clinical audit cycles are completed fully with a date for re-audit and corrective actions, to be able to gauge the effect of changes made.
- Ensure systems are effective to check and identify when emergency medicines and vaccines have reached their expiry date, so that these are disposed of.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood their roles and responsibilities in raising concerns, and reporting incidents. Lessons were learned from incidents and these were communicated throughout the practice. The practice had assessed risks to those using or working at the practice and kept these under review. There were sufficient emergency procedures in place to keep people safe. We did find some issues, for instance equipment calibration checks were all overdue, however this had already been identified and a date booked in the near future to test equipment. There were sufficient numbers of staff with an appropriate skill mix to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Quality data showed patient outcomes were at or above average for the locality. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and people's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles, and had protected learning time to facilitate ongoing training. Clinical staff undertook audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice had initiated extended opening hours and had recently implemented 'sit and wait' clinics in response to patient demand. The practice had a good overview of the needs of their local population, and had engaged with the Clinical Commissioning Group (CCG) and secured

Summary of findings

service improvements where these were required. The practice had good facilities and was well equipped to meet patient need. Information was provided to help people make a complaint, and there was evidence of shared learning with staff.

Are services well-led?

Good

The practice is rated as good for well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by management, and the practice had received accreditation as an advanced training practice. The practice had published a clear mission statement, values to work to, and clear aims and objectives. There were systems in place to monitor quality and identify risk. The practice had an active Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG and staff feedback.

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 people. The practice held multi-disciplinary meetings to discuss those with chronic conditions or approaching end of life care, and care plans had been produced for these. Information was shared with other services, such as out of hours services and district nurses. Nationally reported data showed the practice had good outcomes for conditions commonly found in older people. People approaching end of life could access inpatient services at the local community hospital and stay under the care of the same GP.

People with long term conditions

Good

The practice is rated as good for people with long term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were appropriately monitored, and were involved in making decisions about their care. Nurses communicated with a clinical lead GP for each condition. Attempts were made to contact non-attenders to ensure they had required routine health checks.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place to identify children who may be at risk. For instance, the practice monitored levels of children's' vaccinations and attendances at A&E. Immunisation rates were high for all standard childhood immunisations. There were designated mother and baby clinics, and people could also access midwife services. Full post natal and 6 week baby checks were carried out by GP's, and regular 'well baby' clinics could be accessed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for this population group. The needs of the working population had been identified, and services adjusted and reviewed accordingly. Routine appointments could be booked

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in advance, or made online. Repeat prescriptions could be ordered online. Patients could also access a new 'sit and wait' service to see a GP. Longer appointments and extended hours opening were available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for this population group. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. People or their carers were able to request longer appointment in needed. The practice had a register for looked after or otherwise vulnerable children and also discussed any cases where there was potential risk or where people may become vulnerable. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for this population group. Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. The practice made referrals to other local mental health services as required. The practice had a register of those with a learning disability and these patients were invited for an annual health check-up.

Summary of findings

What people who use the service say

In the most recent NHS England GP patient survey, 84% of patients reported their overall experience as good or very good, which was slightly below the national average at 85.7%. However 84.7% said their GP was good at involving them in decisions about their care, which was above the national average of 81.8%. 95% said the nurses were good at treating them with care and concern.

Areas where patients were less satisfied were seeing a preferred GP, which was 28.1%, below the national average of 37.6%, and 67% of patients saying they were satisfied with the opening hours, below the national average of 79.8%. The practice patient survey of February 2014 also indicated a similar result, with 69% saying they found the opening hours convenient. The provider had recently implemented three 'sit and wait' sessions throughout the day, and had in place some extended opening hours for pre-booked appointments.

We spoke to a member of the Patient Participation Group (PPG) and 10 patients during the inspection. We also collected 27 CQC comment cards which were sent to the practice before the inspection for patients to complete.

The vast majority of patients we spoke to and the comment cards indicated they were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. Patients said they were happy with their medical treatment, and that they received referrals to other services where required, and also received test results within a good timescale, and that any problems were followed up thoroughly.

The most frequent complaint was the time taken to get through on the telephone to make an appointment. The practice patient survey showed 52% of patients did not find it easy to get through on the phone. Patients were also less satisfied with the waiting time to make an appointment to see the doctor of their choice, or for non-urgent appointments. The 'sit and wait' clinics had been implemented too recently to gauge whether this would improve patient feedback in this area. The practice was intending to evaluate the service initially in February 2015. Some patients also remarked that the reception area could be improved, with better information for patients.

Areas for improvement

Action the service SHOULD take to improve

- Identify through risk assessment all staff positions which would benefit from safeguarding training and implement this at a level appropriate to the role.
- Ensure clinical audit cycles are completed fully with a date for re-audit and corrective actions, to be able to gauge the effect of changes made.
- Ensure systems are effective to check and identify when emergency medicines and vaccines have reached their expiry date, so that these are disposed of.

Beech Tree 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 two specialist advisor GPs, a Practice Manager and an Expert by Experience.

Background to Beech Tree Surgery

Beech Tree Surgery provides general medical services (GMS) to approximately 15,600 patients in the catchment area of Selby, Riccall, Carlton and surrounding rural areas. Services are provided from the main surgery at Doncaster Rd, Selby, and also from two small part-time branch surgeries at Riccall and Carlton, which we did not inspect as part of the process. GPs work across all sites and patients can choose to attend at any surgery, although most services, such as chronic disease clinics and minor surgery are provided only from the main surgery.

There are seven GP partners and three salaried GPs, and patients can be seen by a male or female GP as they choose. There is a team of 10 nursing and healthcare assistant staff, with a further nurse lead for this team. They are supported by a team of management, reception dispensing and administrative staff. There are 47 staff in total. The practice is accredited as an advance training practice and supports GP registrars, medical students and staff on modern apprenticeship schemes.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury. The practice population aged under 39 years is lower than the England average, and correspondingly has higher levels of older people, especially those aged 60-69. The practice is in a comparatively less deprived area than the average for the Vale of York Clinical Commissioning Group (CCG).

Out of Hours services are provided through Harrogate Foundation Trust, which patients access via the 111 service. The practice has recently formed an alliance with five other practices in the area, under the SHIELD banner (Selby area Healthcare Initiative for Enhanced Local Development).

Why we carried out this inspection

We inspected this service as part of our inspection programme. The provider was selected at random from the CCG area.

We carried out the inspection 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.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also spoke with a member of the Patient Participation Group. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 9 December 2014.

We reviewed all areas of the main surgery at Doncaster Road, Selby, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with assistant managers, the practice manager, GP's, nursing staff, healthcare assistants, and administrative, dispensing and reception staff.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, and complaints, some of which were then investigated as significant events. Prior to inspection the practice gave us a summary of seven significant events from the period October 2013- October 2014.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was a lead GP for significant events, who staff were able to name. The records showed that staff reported incidents, including their own errors. Staff we spoke to were aware of incident reporting procedures and how to access these, and felt encouraged to report incidents. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. The practice worked with the Clinical Commissioning Group (CCG) in reporting any incidents of poor performance and missed follow up.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found that GPs and nurses were aware of the latest best practice guidelines and incorporated this into their 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 reviewed safety records and incident reports and minutes of meetings where these were discussed for the previous year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed, and the information then shared across the practice as learning points. Significant event meetings were held quarterly or ad hoc if a situation was urgent. Staff could access minutes form these or could also be given feedback directly either verbally or via email. Staff were able to give examples of were procedures had changed following an incident, for instance additional checks around vaccines.

While the practice carried out significant analyses and identified learning points from these, at times the written records for these were not sufficiently detailed to fully describe the incident, clearly identify all possible root causes for the event, corrective actions and who would be responsible for implementing these, therefore some opportunity for learning and improvement may have been missed.

We could see from a summary of significant events that where necessary the practice had communicated with patients affected to offer a full explanation and apology, and told what actions would be taken as a result.

National patient safety alerts were disseminated by email or via the intranet, and staff were able to give recent examples of alerts relevant to them and how they had actioned them, such as recalling patients for medication reviews.

Reliable safety systems and processes including safeguarding

The practice had up to date 'child protection' and 'vulnerable adult' policies and procedures in place, which staff could access via the intranet, and which contained contact details for social services, the police and charity organisations such as Age Concern and drug and alcohol services.

Procedures provided staff with information about identifying, reporting and dealing with suspected abuse. Staff knew how to access these. Staff were able to described types of abuse and how to report these. The practice had two named GP safeguarding leads, who staff were able to identify. Clinical staff had been trained in safeguarding at a level appropriate to their role.

Non-clinical staff had not received safeguarding training, but were directed to policies and information on the intranet. These staff were able to say how they would access guidelines and how they would report any concerns to a GP, although in the absence of safeguarding training there was a risk that front of house staff would not recognised an abuse situation in order to report it.

Good

Are services safe?

The practice had a register for looked after or otherwise vulnerable children. Health visitors attended regular multi-disciplinary meetings at the practice, although safeguarding was not a standing agenda item on these. GPs and health visitors could also meet informally to discuss specific cases, although this was not documented therefore could not be verified. The children's' safeguarding lead had carried out a safeguarding children self-assessment exercise in November 2014 which highlighted areas the practice wished to improve, such as documenting a lead GP for each vulnerable family and introducing regular child protection meetings with health visitors from early 2015.

The computerised patient plans were used to enter codes to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. The practice had systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

The practice had chaperone guidelines, and there was information on this service for patients in reception.

The recruitment policy of the practice stated that candidates would only be offered a position following receipt of reference, satisfactory Disclosure and Barring Services (criminal records) checks, proof of identity and completed checks on professional qualifications.

Medicines Management

The practice dispensed from its two smaller branches, and not from the main site. However the main site was used as a storage and distribution hub for the two smaller sites. Medicines stored in the practice were kept securely and could only be accessed by appropriate staff.

We checked medicines stored in the fridges and found these were in the main stored appropriately, although we did find four travel vaccines which had recently expired. The practice manager said they would carry out a full investigation, and contacted us after the inspection to say that they were originally for named patients when supplies were short. The patients attended when supplies were replenished and were vaccinated from normal stocks. The originals were then missed when the fridge was checked.

Appropriate checks took place to make sure refrigerated medicines were kept at the correct temperature, and it was documented where maximum temperatures had been exceeded, for instance because the fridge was being restocked. Appropriate arrangements were in place to transfer refrigerated medicines in cool bags to the branch sites.

We saw evidence that the doctors bags were regularly checked to ensure that the contents were intact and in date, although we did find a minority of emergency medicines which were out of date.

Clear records were kept of any medicines stored in the practice and records of when they were used. Stock totals of medicines we checked correctly tallied with the practice records, and non-refrigerated medicines we checked were within their expiry dates. Prescriptions were stored securely, and there was a system in place for GP's to double check repeat prescriptions before they were generated. Any errors were logged as incidents and investigated.

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

GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. The practice had a prescribing and medication policy which was regularly reviewed and had been agreed with the CCG medicines management team.

Cleanliness & Infection Control

We observed all areas of the practice to be clean, tidy and well maintained. Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC), waste disposal and legionella testing policies, and these were reviewed and updated regularly. There was an identified IPC lead. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas as was hand sanitizer and safe hand washing guidance, although there was no hand sanitizer in reception.

Good

Are services safe?

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place. Cleaning was carried out by an external company and cleaning checklists were audited by the practice manager. Public toilets were observed to be clean and have supplies of hot water, soap, paper towels, as did treatment rooms.

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

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

The practice had recently carried out an infection control audit with input from Harrogate Foundation Trust, and had drawn up a plan of corrective actions. The practice had recently carried some improvements, such as fitting disposable curtains in all treatment and consulting rooms. There had not been regular, formal infection control audits in the past, although the infection control lead now planned to introduce these. We did find some minor issues, such as visible dust on a wall mounted blood pressure gauge, and rips in a plastic pillow cover.

Equipment

We found that most equipment such as scales, spirometer, ECG machines (used to detect heat rhythms) and fridges had been due for external calibration checks in September 2013. As a member of staff had left these had been missed and were now booked in for January 2015. The practice manager explained that as a result of this there were now procedures in place to ensure that equipment was checked and calibrated on a timely, regular basis to ensure it was functioning correctly.

Contracts were in place for checks of equipment such as the lift, fire extinguishers, and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment was now overseen by the practice manager.

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave, with GPs operating in buddy groups to cover one another.

Staff and partner GPs explained there had been staff shortages over summer due to staff sickness. Most staff said the situation had improved recently. Sick leave of GPs was covered by locum doctors or by part-time partner GPs taking on extra sessions.

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

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly

Good

Are services safe?

checks and risk assessments of the building, the environment and equipment, and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk.

Patients with a change in their condition or new diagnoses were reviewed appropriately, which allowed clinicians to monitor treatment and adjust according to risk. Therefore the practice was positively managing risk for patients. Patients with an emergency or sudden deterioration in their condition could be referred to an on call doctor for quick assessment. Information on such patients was made available electronically to out of hours providers so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

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

A business continuity plan and emergency procedures were in place which had been recently updated, which included details of scenarios they may be needed in, such as loss of data or utilities. Some emergency contact numbers in this needed updating, which the practice manager was in progress with. If required the practice could relocate to one of the branch surgeries to continue operating a basic service. Weekly fire alarm checks took place and fire drills every six months.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. There was also a defibrillator and oxygen available. Processes were in place to check emergency medicines were within their expiry date, although we did find two items of emergency medication in a doctor's bag which had expired.

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 Clinical Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into their practice and disseminated via computer system as assigned tasks, or via email.

Treatment was considered in line with evidence based best practice, and we saw minutes of clinical staff meetings where new guidelines and protocols were discussed. Clinical meetings with the partners had been held only monthly, however this was to change to fortnightly to ensure clinicians were kept up to date and to improve communication, as it was acknowledged monthly meetings were not best practice. All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge. Nurses met with the lead GP for their area of chronic disease management.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. For instance, we saw one clinical review of a medicine with potential side effects. Patients on this medicine had been identified and advised to come for a blood test. The system was also altered so an alert that a blood test was needed displayed to the GP when the patient attended for another reason.

Practice nurses told us they managed specialist clinical areas such as diabetes, heart disease and asthma, in conjunction with a lead GP. 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. For instance, there was a fortnightly diabetes meeting with the practice nurses and lead GPs to discuss ongoing cases. Active monitoring of patient outcomes took place through clinical audit and the quality and outcomes framework.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates, and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept 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.

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. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GP's we spoke with used national standards for referral, for instance two weeks for patients with suspected cancer to be referred and seen.

The practice could produce a list of those with learning disabilities or who were in need of palliative care and support. Patients requiring palliative care were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

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

Management, monitoring and improving outcomes for people

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. Latest QOF data from 2013-14 showed the practice had an overall rating of 96%, one point below the CCG average, but above the England average. The data showed the practice supported well patients with long term conditions such as diabetes, asthma, and chronic heart disease.

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 practise analysed to see whether they could have been improved.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in

the area, for instance the practice looked at referral pathways and compared these against criteria. This benchmarking data showed the practice had outcomes comparable to other services in the area.

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). The practice carried out some clinical audits, examples of which included the process for dealing with urine samples, monitoring of patients attending for blood tests who were prescribed a particular medicine, and auditing of hospital discharge medication compared to the patients repeat medication list from the GP . However these did not always contain sufficient detail. A future date was not always included for re-audit to gauge the success of any corrective actions, meaning learning opportunities could be missed. For instance, the audit dealing with urine samples had a re-audit carried out which showed one result had got worse, but this had not then been further analysed and different corrective actions identified.

Nurses had monthly clinical practice meetings, as did GPs, although this was to change to fortnightly meetings for GPs in the near future. Clinical staff checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued, and when people needed to attend for routine checks related to their long term condition.

Effective staffing

The practice manager oversaw a training matrix which showed when essential training was due. The assistant practice manager and lead nurse drew up a training schedule for the year which included internal and external training. Staff told us the practice was supportive of relevant professional development. Nurses had one hour a month protected learning time to attend tutorials, and said they were supported in attending external courses.

We saw evidence that all GP's had undertaken annual external appraisals and had been revalidated or had a date for revalidation, an assessment to ensure they remain fit to practice. Continuing Professional Development for nurses was monitored by the lead nurse as part of the appraisals process, and professional qualifications were check yearly to ensure clinical staff remained fit to practice.

Dispensing, reception and administrative staff had not been appraised since early 2012. The practice was aware of this. The recently appointed assistant practice manager was leading on this and had scheduled all these staff for appraisal the week following the inspection. Clinical staff had been or were about to be appraised.

The recruitment policy of the practice showed that relevant checks were made on qualifications and professional registration as part of the process. On starting, staff commenced an induction comprising health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff.

We saw that the mandatory training for clinical staff included safeguarding and infection control. Staff also had access to additional training related to their role.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support, and were able to give examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure. 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.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases, for instance regular multi-disciplinary meetings were held with district nurses, Macmillan nurses and GPs to identify and discuss the needs of those requiring palliative care, or those who would require it. GPs could admit palliative care patients to the local community hospital and continue to care for them there. GPs provided cover for minor injuries and the in-patient unit at this hospital.

Health monitoring of patients with long term conditions was discussed at monthly clinical meetings between GPs, and weekly between nurses and the lead GP for that area,

Good

Are services effective?

(for example, treatment is effective)

to discuss and review treatment strategies and any required actions or changes. Quarterly meetings took place to discuss patients deemed at high risk of unplanned admission, and these were attended by district nurses and community matrons. The practice accepted that communication across the practice could be difficult due to the number of staff and multiple sites, and was instigating more frequent clinical meetings to help address this.

The practice signposted to local services within the area, such as a drug and alcohol intervention service and dementia support service.

The practice was a member of the 'SHIELD' federation, a newly formed group of six practices in the local area, which was aiming to improve collaborative working, leading to efficiencies and improved healthcare, such as working with secondary care providers to reduce emergency admissions to hospital. The district nurse team, midwives and health visitors were based on site, which facilitated good communication, although much of this was informal.

Information from out of hour's services was disseminated to the appropriate GP who checked as a first task each morning. The practice kept 'do not resuscitate' and advance decision registers to reflect patient's wishes, and this information was made available to out of hours providers.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated straight to the relevant doctor, or the duty doctor, or where necessary a procedure for scanning documents was in place. There was a system to ensure scanned documents were not sent to a doctor who was on leave, and the GP's operated a buddy system to check each other's results if one was off. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information Sharing

Information was shared between staff at the practice by a variety of means. There were no practice-wide meetings. GPs held management and clinical meetings, nurses held clinical meetings, and distinct groups of staff such as reception and dispensing staff held their own meetings. Some of these had become less frequent and the practice was looking to reinstate them.

Feedback from staff regarding communication was mixed, with some staff highlighting a delay in information being passed on after management meetings, or a lack of involvement in decision making. Staff said they did receive regular email communications from the practice manager, although fed back they would welcome more cross-departmental staff meetings to improve communication and information sharing.

Referrals were completed using an electronic system, and these were completed within appropriate protocols. There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. The practice used an electronic end of life care co-ordination system, which meant that other providers such as ambulance crews and hospital staff could view and access information about a patient. Urgent information could also be sent or received via fax.

Consent to care and treatment

We found that clinical staff had received some training around the Mental Capacity Act 2005, albeit some time ago, and were able to describe key aspects of the legislation and how they implemented it. Further information was available for staff on the practice intranet.

For instance, GPs explained examples where people had recorded advance decisions about their care or their wish not to be resuscitated. Where those with a learning disability or other mental health problems were supported to make decisions, this was recorded. If someone had lasting power of attorney concerning a patient this was recorded on the computer and in the patients plan.

There was a practice policy on consent to support staff and staff knew how to access this, and were able to provide examples of how they would deal with a situation if someone did not have capacity to give consent, including escalating this for further advice to a senior member of staff where necessary.

Staff were able to discuss the carer's role and decision making process. Verbal consent was documented on the computer as part of a consultation. Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, which allowed patients to make an informed choice.

Health Promotion & Prevention

Good

Are services effective?

(for example, treatment is effective)

The practice offered all new patients an assessment of past medical history, care needs and assessment of risk. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. Patients over the age of 75 had been allocated a named GP and had been sent information about this. Nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition.

Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. The practice website contained information on a number of long term conditions, with links to support organisations.

In addition to routine immunisations the practice offered travel vaccines, and flu vaccinations in line with current national guidance. Well woman, ante- and post natal clinics were offered, as were childhood immunisation clinics. Data showed immunisation rates were broadly comparable with the CCG area. Flu vaccinations for the over 65 age group were below the national average in 2012-13. We saw that the practice was advertising this service in their practice newsletter, on their website and via social media. The practice website gave information on healthy living, available clinics and health promotion.

The practice's performance for cervical smear uptake was above the CCG and England average. There was a policy to follow up patients who did not attend for cervical smears and the practice audited rates for patients who did not attend.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

In the most recent NHS England GP patient survey, 84% of patients reported their overall experience as good or very good, which was slightly below the national average at 85.7%. However 84.7% said their GP was good at involving them in decisions about their care, which was above the national average of 81.8%. 95% said the nurses were good at treating them with care and concern.

From the practice annual survey of 251 responses in February 2014, 92% of patients said their GP was good or very good at giving them enough time during consultations, and 90% of patients said they were treated with care and concern.

We spoke to 10 patients during the inspection, and collected 27 CQC comment cards which were sent to the practice before the inspection for patients to fill in. The vast majority of patients we spoke to and the comment cards indicated they were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable.

The dignity and privacy of patients in the reception area was a concern raised by 33%, of patients in the practice patient survey. This was not raised by patients we spoke to on the day at the main site, and was acknowledge by the provider to be a problem at the much smaller branch sites. As a result of the survey, some improvements such as a portable barrier and privacy film had been fitted at the main site. However the response in the 'You said- we will' section of the action plan following the patient survey said only that improvements were not possible at the branch sites due to their physical size, and did not, for instance, promote a private area which patients could access if required.

The practice phones were located away from the reception desk and the desk was shielded by glass partitions which helped keep patient information private. A system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, and a poster advertising the service in reception. Nursing staff acted as chaperones where requested.

Care planning and involvement in decisions about care and treatment

In the practice survey, 85% of patients 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, for instance the decision of diabetic patients whether to start taking insulin.

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

People said the GP's 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 information leaflets were available in different languages on the practice website, and the webpage had a 'translate' facility.

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 service to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service. In the most recent practice survey, 91% of patients said the GP was good or very good at listening to them.

Good

Are services caring?

GP's referred people to bereavement counselling services where necessary, although there was no information about this in reception. Where people had suffered a bereavement, the practice sent a standard condolence letter to the next of kin.

The practice kept registers of groups who may need extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided. All GP's had received training in end of life care and 'breaking bad news' to enable an appropriate caring service to be provided.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified 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, for instance patients with diabetes, and patients could book with a specific GP to enable continuity of care.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow these up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Extended hours appointments were available on Mondays and Tuesdays which would benefit the working population and parents bringing children outside of school hours. Home visits and telephone appointments were available where necessary.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as level access, automatic doors and level thresholds. All treatment/ consulting rooms and patient toilets were on the ground floor. A number of disabled parking spaces were available in the car park outside.

There was a practice information leaflet available in reception, covering subjects such as services available, staff list, and how to book appointments. There was a hearing loop at reception to assist those hard of hearing. Patient information leaflets were available in other languages on the practice website.

The practice had recognised the needs of different groups in the planning of its services. The practice had two traveller sites within its catchment area and patients from the sites were able to access services without difficulty. Patient records were coded to flag up to GPs when someone was living in vulnerable circumstances or at risk.

Access to the service

Information was available to patients about appointments on the practice website and patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

Appointments could be made in person, by telephone or online. Repeat prescriptions could be also be ordered online. The practice promoted its online services via patient newsletters and social media, and had high uptake rates of these services, with 22% of patients being registered for online access.

The practice had extended opening hours on Mondays and Tuesdays, when the main site was open from 7am until 7.30pm, for pre-booked appointments between 7am-8am and 6pm-7.30pm. Opening times and closures were advertised on the practice website, with an explanation of what services were available.

During core times patients could access a mix of doctors, nurse practitioners, nurses & health care assistants, or clinics such as family planning and for chronic conditions. Patients could either attend at the main or branch surgeries to suit, although some services such as clinics were only available from the main site. The most recent practice patient survey showed that 82% of patients were seen within 10 minutes of their appointed consultation time. Patients we spoke with told us their appointments generally ran to time.

The most common negative from patients was difficulty accessing the surgery via the phone to make an appointment. The practice was active in monitoring patient access to the service, and patient feedback regarding this, and had recently initiated some changes such as an increase in telephone appointments, increase staff numbers to answer the phone at peak times, 'sit and wait'

Good

Are services responsive to people's needs?

(for example, to feedback?)

clinics and telephone reviews for a limited number of some long term conditions. The practice was intending to review these changes in early 2015 to assess if they had improved access.

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. Information on how to complain was contained in the patient information leaflet in reception, and staff were able to signpost people to this.

We looked at a summary of complaints made during 2014, and could see that these had been responded to with a full explanation and apology. Details of the ombudsman had been made available. The practice carried out a patient survey in February 2014. An action plan was then drawn up and discussed with the PPG to look at the lowest results. Results of this survey were available on the practice website. Information on how to make a complaint was available in the practice leaflet in reception, and there was a suggestion box where patients could leave feedback through the 'Friends and Family' test.

The practice summarised and discussed complaints with staff at practice meetings, and was able to demonstrate changes made in response to feedback, such as improvements in confidentiality and changes to the appointment system.

People we spoke to said they would feel comfortable raising a complaint if the need arose.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear mission statement to improve the health and well-being of patients and provide good quality care, although awareness of this varied among staff. The practice had a clear vision to deliver high quality care and promote good outcomes for patients, and had developed published values and behaviours to help them achieve this. The practice had a senior management team which held regular meetings to analyse how they thought the practice was performing, problem areas, and opportunities and threats for the future.

Staff did not have specific individual objectives via their appraisal which fed in to corporate objectives, however the practice was looking to develop this in the coming year.

Governance Arrangements

Staff were clear on their roles and responsibilities, and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in.

Audits on subjects such as infection control, equipment checks, and repeat prescribing were recorded, although these did not always include a date for re-audit or name staff with specific responsibilities for tasks.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed was performing in line or above national standards, and the practice regularly reviewed its results and how to improve. The practice had identified lead roles for areas of clinical interest, safeguarding, or management tasks, and had a coherent strategy and aims for the future. There was a programme of clinical audit, subjects selected from QOF outcomes, from the CCG, following an incident or from the GP's own reflection of practice.

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

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care. Staff described the culture at the practice as open and honest, and said they felt confident in raising concerns or feedback.

GP partner's described a major business strength of having a strong, cohesive staff team, and this was echoed by staff who described strong supportive team working within their areas. There was a clear chain of command and organisational structure. While communication within teams was good, this was less so across the whole practice, and acknowledged as a difficulty by the provider given the multiple sites and number of staff. Some staff gave examples in delays in communication, and said while they could input ideas and suggestions, they would welcome the opportunity to do this on a more frequent, formalised basis.

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

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

We saw some examples from the patient survey where the practice had made changes, for instance, refurbishment of one of the branch surgeries. Where suggestion could not be implemented the practice explained why. The action plan completed from the patient survey included a 'You said- we did' section, which included some completed actions such as increasing the number of available telephone consultations.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. Staff told us they generally felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistleblowing policy which was available to all staff.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to access protected learning time where

Are services well-led?

Good

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

necessary. We saw that appraisals took place where staff could identify learning objectives and training needs. Although a number of staff had not been appraised in the previous year, a member of staff had been allocated responsibility for this task, and all those staff were scheduled to be appraised shortly after the inspection.

The practice was a training practice and supported medical students and GP registrars. The practice had completed reviews of significant events and other incidents, and shared these with staff via team meeting discussions to ensure the practice improved outcomes for patients, although the recordings of these discussions sometimes lacked detail. Staff told us the culture at the practice was one of continuous learning and improvement.