Trent View Medical Practice

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 4 February 2015.

Overall, we rated this practice as good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice provided a good standard of care, led by current best practice guidelines.
- The majority of people told us they were treated with dignity and respect.
- The buildings were clean, and the risk of infection was kept to a minimum by systems such as the use of disposable sterile instruments.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

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

While patients could generally access appointments, feedback from the national GP patient survey and NHS Choices showed a number of people were dissatisfied with the wait to see their GP of choice.

The provider should:

- Continue to explore solutions to improve patient satisfaction at being able to access their GP of choice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. 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 the practice facilitated 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 providing caring services. The majority of feedback gathered through the inspection process was positive, with patients stating they were treated with compassion, dignity and respect, and involved in their treatment and care. There was a minority of negative feedback regarding the consulting styles of some doctors both during the inspection and in the latest national GP patient survey. While national survey results were below the national average for how many people thought the doctor treated them with care and concern, these figures had improved from the previous survey. The practice buildings were accessible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated extended opening hours and implemented more pre-bookable appointments in response to patient demand, although feedback from patients reported that access to a named GP and continuity of care was not always available quickly. Urgent appointments were usually available the same day. The practice had a good overview of the needs of their local population, and had engaged with the Clinical Commissioning Group (CCG) and secured

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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 being well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by management. The practice had a clear business plan with 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. Care plans were produced for those patients deemed to be at risk of unplanned admission to hospital, and at risk patients were allocated a care co-ordinator. The over 75's had a named GP. Information was shared with other services, such as out of hours services. Nationally reported data showed the practice had good outcomes for conditions commonly found in older people. The practice visited nursing homes in its area three times a week to offer a high level of service.

People with long term conditions

Good

The practice is rated as good for the care of 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 care 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. Full post natal and six week baby checks were carried out by GP's.

Working age people (including those recently retired and students)

Good

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

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reviewed accordingly. Routine appointments could be booked in advance, or made online. Some video consultations were available. Repeat prescriptions could be ordered online. Longer appointments and extended hours opening were available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. These could be carried out at the person's home to minimise anxiety for the patient. Patients or their carers were able to request longer appointments if needed. The practice held specific clinics, for instance substance misuse, where patients could have their needs assessed. 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. There was a home delivery service for medication for those who may struggle to access the service.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. For instance, 94.9% of patients diagnosed with dementia had their care reviewed in last 12 months, which was above the national average. The practice had a mental health clinical lead who was responsible for overseeing services to patients with mental health problems. The practice ran dedicated clinics for patients with serious mental illness where their physical and mental health needs were assessed. The practice worked with other local mental health services as required and had links with local mental health crisis teams.

Summary of findings

What people who use the service say

There was some inconsistency in patient feedback, with patient comments collected directly through the inspection process generally more positive than national patient surveys or internet comments.

In the NHS England GP Patient Survey from July 2013-March 2014 66.3% of patients reported their overall experience as good or very good (below the national average at 85.7%). This figure was 65% from the latest survey results published in January 2015. From July 2013-March 2014, 67.3% of patients said their GP was good at involving them in decisions about their care (below the national average of 81.8%). The published January 2015 figure had improved to 75%. 69.9% of patients said the GP was good or very good at treating them with care and concern (below the national average of 85.3%), although this improved to 78% in January 2015.

From the GP Patient Survey results published in January 2015, areas of highest satisfaction included patients saying they had confidence in the nurses, and the nurses gave them enough time during appointments. The areas of least satisfaction were in overall experience and seeing a preferred GP, with only 52% of patients saying they would recommend the practice. 42% said it was not easy to get through on the phone, and only 30% of patients said they were able to see the GP they prefer, although 73% of people said they managed to get an appointment last time they tried.

The practice had also carried out a survey of patients from November to December 2013, of 43 responses, 40 patients were satisfied with the opening hours. 72% of patients said they found telephone access easy or fairly easy, and 88% said they were happy with how the doctor or nurse listened to them. Results were generally more positive than the national patient survey, however the questions and sample sizes were not directly comparable.

The practice website contained links to the NHS Choices website, where a number of patients had left negative feedback about all three branches, on subjects including attitude of receptionists and doctors, and difficulty getting appointments. However there were also some very positive reviews from patients praising the service and their care.

We spoke to two members of the Patient Participation Group (PPG) and four patients during the inspection. We also collected 94 CQC comment cards which were sent to all three sites of the practice before the inspection for patients to complete.

The vast majority of feedback collected on the day indicated patients were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. The most frequent complaint was the waiting time to make an appointment to see the doctor of their choice.

Areas for improvement

Action the service SHOULD take to improve

Continue to explore solutions to improve patient satisfaction at being able to access their GP of choice.

Trent View Medical Practice

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 specialist advisor GP, a pharmacist, and a Practice Manager.

Background to Trent View Medical Practice

Trent View Medical Practice provides general medical services (GMS) to 11,800 patients. The practice is based in Keadby, near Scunthorpe, North Lincolnshire. Two additional branch surgeries are based at nearby Crowle and Skippingdale. We visited the surgeries at Keadby and Crowle as part of this inspection. The practice provides a service to residents of both urban areas of Scunthorpe and rural areas of the Isle of Axholme and covers a sixty mile radius. GPs, clinical and some administrative staff work across all sites, although some services such as minor surgery are provided only from the Skippingdale site. The site at Keadby is a converted house and the two branches are purpose built.

There are nine GP partners and one salaried GP, six female and four male. Patients can be seen by a male or female GP as they choose. There is a team of one nurse practitioner, two practice nurses, and three healthcare assistants. They are supported by a team of management, reception, dispensing and administrative staff.

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

Out of Hours services are provided through Core Care Ltd, which patients access via the NHS 111 service.

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

Why we carried out this inspection

We 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.

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 4 and 5 February 2015.

We reviewed all areas of the main surgery at Keadby including the administrative areas over two days. We then also visited the Crowle branch on 5 February 2015. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GP's, nursing staff, healthcare assistants, and administrative, dispensing and reception staff. We also spoke with two members of the Patient Participation Group.

We observed how staff handled patient information received from other services 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 eight significant events from within the last 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The records showed that staff reported incidents, including their own errors. 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 incidents where appropriate.

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 the provider was appropriately identifying and reporting significant events.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. These 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 at partner meetings, and the information then shared across the practice as learning points. Staff could access feedback directly via email, staff meetings, or verbally if it concerned them directly. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Incident forms were available on the practice intranet and staff knew how to access these.

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. The practice could demonstrate where changes had taken place as a result of an incident, such as additional authorising procedures before patient information was shared.

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 changes to medication guidance.

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 local safeguarding authorities.

Information was available to staff about identifying, reporting and dealing with suspected abuse. Staff knew how to access this. Staff were able to described types of abuse and how to report these, and the practice was able to show evidence of safeguarding concerns they had raised in the past. The practice had a named GP safeguarding lead, who staff were able to identify. Staff had been given training in safeguarding children and adults at a level appropriate to their role.

The practice had a register for looked after or otherwise vulnerable children. 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.

Good

Are services safe?

Medicines Management

The practice dispensed from the main site and one of the branches. 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 stored appropriately. Daily checks and monthly audits 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. Procedures were in place to transfer refrigerated medicines in cool bags to the branch site, although there was not a system to log times out and in, therefore the practice could not verify how long medicines had not been held at a controlled temperature.

We saw evidence that the doctors bags were regularly checked to ensure that the contents were intact and in date. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that prescribed medicines always reflected patients' current clinical needs. Blank prescription forms were handled in accordance with national guidance and kept securely at all times. Any errors were logged as incidents and investigated.

Vaccines were administered by nurses using Patient Group Directions (PGDs) that had been produced line with national guidance. These had been signed by all the Nurses but not the Authorising Manager. We saw evidence that clinical staff had received appropriate training to administer vaccines. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. Mentorship was provided to trainee dispensing staff to support them to complete certificated dispenser training. Appropriate standard operating procedures were in place which staff followed.

GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. There were two GP prescribing leads who oversaw prescribing practices, including looking to reduce unnecessary medications. 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.

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 infection control lead. Public toilets were observed to be clean and have supplies of hot water, soap, and paper towels.

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.

Regular infection control audits were carried out by the lead staff member, and the findings communicated to all staff. The practice had recently carried out some improvements, such as fitting disposable curtains in all treatment and consulting rooms.

Equipment

Good

Are services safe?

We found that equipment such as scales, spirometer, ECG machines (used to detect heart rhythms) and fridges were on external contracts to be checked and calibrated on a timely, regular basis to ensure they were functioning correctly. Regular external checks were carried out on equipment such as fire extinguishers and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were 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 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.

The practice was actively seeking to recruit new GPs to decrease the long-term need for locum cover, and a nurse prescriber to work closely with GPs. Staff told us there were enough staff to maintain the smooth running of the practice and keep patients safe. Staff could swap between sites in response to patient need and some roles were 'floating' so the staff member could go where they were needed.

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks 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. Staff were aware of how to access the Mental Health 'Crisis Team' for those undergoing urgent mental health difficulties. Information on patients was made available to out of hours providers as required 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 could describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose. Staff members could provide floating support to different sites where needed to cope with additional demand.

A business continuity plan and emergency procedures were in place which had been reviewed, which included details of scenarios they may be needed in, such as loss of data or utilities. If required the practice could relocate to one of the branch surgeries to continue operating. Fire drills were held every six months and regular fire safety checks were carried out.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. Processes were in place to check emergency medicines were within their expiry date. There was no defibrillator at the practice. Emergency oxygen was available. This had not been serviced within the manufacturer's guideline of three years, but was within the mandatory five year limit. The practice immediately arranged to have the oxygen cylinders serviced after the inspection.

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 email.

Treatment was considered in line with evidence based best practice. Clinical meetings with the partners were held twice a month to ensure clinicians were kept up to date. All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge. Nurses worked alongside GPs within their guidelines for their area of chronic disease management, and discussed patients' needs before the GP prescribed. GPs maintained lead areas of special interest and knowledge, such as drug misuse, mental health, child health and prescribing.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. For instance, the practice was participating in the Unplanned Admissions Enhanced service and in the CCG Elderly Care fund scheme to improve care of the elderly and reduce acute hospital admissions (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). An extra part-time member of nursing staff had been employed to complete and monitor care plans for the at risk elderly. All over 75s had a named GP and those on the at-risk register were also appointed a care co-ordinator.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented. We were shown the process the practice used to review patients recently discharged from hospital. Within 72 hours the patient was contacted by the care co-ordinator, who then liaised with the named GP for appropriate action. Care plans were reviewed after each consultation.

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 95.7%, above the CCG and England averages.

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. For instance, the practice had recognised the number of diabetic patients offered foot health screening in the previous 12 months was below that of the CCG and England averages. This was discussed at a practice meeting, and as a result all three health care assistants were trained to perform diabetic foot screening. Patients were being actively called for this service and the practice expected their QOF performance to improve from 80.1% to the QOF target of 90% as a result of this change.

The practice 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

Good

Are services effective?

(for example, treatment is effective)

area, for instance the practice looked at referral rates and A&E admissions 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 QOF. For instance, one audit was carried out on the use of an anti-sickness medicine following a change in issued guidelines highlighting an increased risk of some side effects. Patients were flagged for a medication review and as a result the practice had reduced the drug's usage by 75%. Examples of other audits included efficacy of a minor surgery procedure, reporting on blood tests for patients with kidney disease, and a review of the efficacy of cancer diagnoses. A future date was included for re-audit to gauge the success of any corrective actions.

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. Training was provided through variety of means including external CCG events, internal training and e-learning. Staff told us the practice was supportive of relevant professional development.

GP's told us they 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 through the appraisals process. Professional qualifications and medical indemnity insurances were checked monthly to ensure clinical staff remained fit to practice.

Staff were appraised annually which generated aims and objectives for staff, with staff able to feed back any problems and what they did well. 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 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 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 to identify and discuss the needs of those requiring palliative care, or those who would require it. The practice was working towards generating closer links with district nurses and local hospitals.

Health monitoring of patients with long term conditions was discussed at regular clinical meetings between GPs, to discuss and review treatment strategies and any required actions or changes. District nurses attended for cancer and palliative care meetings. The practice worked closely with the CCG and attended information sharing meetings in the region.

Information from out of hour's services and NHS 111 contacts was disseminated to GPs to review the next working day so that any required action could be taken. 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 to doctors, although these were allocated randomly among GPs working that day, rather than going to a named GP or the GP who had instigated the referral. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information Sharing

Good

Are services effective?

(for example, treatment is effective)

Information was shared between staff at the practice by a variety of means. There were practice and clinical meetings. A GP representative attended practice meetings, and staff were able to describe how they received information via meeting minutes, the intranet, or emails. There was a process in place to check that all staff read minutes relevant to them. Staff said they found communication across the practice generally good, although the practice did highlight the challenge of running three separate sites.

Referrals were completed by direct letters to the local hospital, and these were completed within appropriate protocols. The practice used the Choose and Book system for referrals where possible. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. Urgent information could also be sent or received via fax.

Consent to care and treatment

We found that clinical staff had received training around the Mental Capacity Act 2005, 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.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health Promotion & Prevention

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. Nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition.

The practice provided substance misuse care to its own patients and those of other practices in conjunction with a local service provision contract holder. Patients aged 40-74 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. New patients were offered health checks.

In addition to routine immunisations the practice offered travel vaccines, and flu vaccinations in line with current national guidance. Well woman, well man and baby clinics were offered. Data showed childhood immunisation rates were broadly comparable with the CCG area. The practice website gave information on available clinics and health promotion.

The practice had a Learning Disability lead to oversee the care of this group of patients. The practice held dedicated clinics to assess the physical and mental health needs of these patients and to promote healthy living such as smoking cessation and to encourage the uptake of screening services. The practice also ran dedicated clinics for patients with serious mental illness where their physical and mental health needs were assessed, promoting the health of these groups.

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke to four patients during the inspection. We also collected 94 CQC comment cards which were sent to all three sites of the practice before the inspection for patients to complete.

The vast majority of feedback collected on the day indicated patients were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. These comments were generally more positive than national patient surveys or internet comments. For instance, in the NHS England GP Patient Survey from July 2013- March 2014 69.9% of patients said the GP was good or very good at treating them with care and concern (below the national average of 85.3%), although this improved to 78% in January 2015.

From the GP Patient Survey results published in January 2015, areas of highest satisfaction included patients saying they had confidence in the nurses, and the nurses gave them enough time during appointments. The practice website contained links to the NHS Choices website, where a number of patients had left negative feedback about all three sites, on subjects including attitude of receptionists and doctors. However there were also some very positive reviews from patients praising the service and their care.

The reception desk was shielded by glass partitions which helped keep patient information private. A system was in place to encourage patients to approach the desk one at a time, to help prevent patients overhearing potentially private conversations between patients and reception staff. There was a separate room where patients could speak in private if they wished.

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 or other trained staff acted as chaperones where requested.

Care planning and involvement in decisions about care and treatment

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 generally 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 telephone translation service available for those whose first language was not English, and we saw details for this service. Some GPs also spoke additional languages and patients were able to request these GPs.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service. In the most recent practice survey, 88% of patients said they were happy with how the GP had listened to them.

GP's referred people to bereavement counselling services where necessary, and there was information about support services in reception. Where people had suffered a bereavement, GPs told us they would contact the next of kin, although this was not covered by a formal arrangement or policy. Carers were recorded in patient notes so extra support could be offered.

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.

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.

Telephone consultations and a home delivery service for medication were available, to help patients who lived in rural areas or may otherwise struggle to access the surgery. Some video consultations were available. Extended hours appointments were available every Monday alternating between Crowle and Skippingdale surgeries which would benefit the working population and parents bringing children outside of school hours.

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.

GPs told us the practice made routine weekly visits to each of the major care homes in the practice area where non-acute problems were discussed in addition to usual care.

Tackling inequity and promoting equality

The buildings accommodated the needs of people with disabilities. All treatment/consulting rooms and patient toilets were on the ground floors. Disabled parking spaces were available.

There was a practice information leaflet available on the website, covering subjects such as services available, staff list, and how to book appointments, although we did not see copies of patient leaflets in reception at the Keadby Surgery. There was a hearing loop at reception to assist those hard of hearing.

The practice had recognised the needs of different groups in the planning of its services, for instance the practice manager told us they tried to be flexible with appointment timings to fit in with local bus timetables. Patient records were coded to flag up to GPs when someone was living in vulnerable circumstances or at risk so extra support could be offered.

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, although the website did still refer to a branch which has now closed. 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. Home visits could be made available where required, for instance for those with mobility issues of learning disabilities. Repeat prescriptions could be ordered online, and the practice offered a medication home delivery service for patients living in rural areas. The practice promoted its online services on the website and via an action plan made with the PPG following a patient survey.

The surgery at Keadby had core hours of 8:20am until 6pm, 6:30pm on Friday. The Crowle branch was the same except the 6.30pm opening was on Tuesday. The Skippingdale branch opened until 6.30pm on Mondays, Wednesdays and Thursdays. Extended opening hours until 9.30pm were on alternate Mondays at the Skippingdale and Crowle branches. 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 we spoke with told us their appointments generally ran to time. The most common negative from patients was difficulty accessing appointments with the GP of their choice. Full-time GPs rotated round each branch,

Good

Are services responsive to people's needs?

(for example, to feedback?)

part-time GPs usually to one or two sites only. Following consultation with the PPG, more pre-bookable appointments had been made available. The practice also promoted nurse practitioner services, alternative consultations, and offering patients an appointment at a different branch. The practice was working with the PPG to understand patient requirements, improve communication between practice and patients, and improve patient satisfaction. The practice had considered other options such as walk-in clinics but decided these would not be the best solution.

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 displayed in reception and the patient information leaflet, and staff were able to signpost people to this.

We looked at a summary of complaints from the last 12 months, and could see that these had been responded to with a full explanation and apology. The practice carried out a patient survey in November and December 2013. 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, and there was a suggestion box in reception where patients could leave feedback. Patients could also access a link to the Friends and Family Test via the practice website.

The practice summarised and discussed complaints with staff at practice meetings, with some raised as significant events, and was able to demonstrate changes made in response to feedback, such as changes to the appointment system, and reminders to reception to offer nurse practitioner services. 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 developed a statement of purpose with a number of aims and objectives setting out what they wished to achieve. These included auditing and optimising performance against key targets and core standards, such as providing patient-centred excellent clinical care.

The practice had a clear vision to deliver high quality care and promote good outcomes for patients, and had developed a business plan with medium and long term objectives to help them achieve this. The partners held regular meetings to analyse how they thought the practice was performing, problem areas, and opportunities and threats for the future.

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. A number of staff had specific lead roles such as infection control, team leader, and management of specific conditions.

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 in most areas, 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. There was a programme of clinical audit, mainly subjects selected from QOF outcomes or the CCG. Audits on subjects such as infection control, equipment checks, and repeat prescribing were recorded, and included a date for re-audit.

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. In addition to the practice manager, there were two named 'staff liaison' GP's who were available for staff to talk to, which gave staff a choice of who to approach if they had problems or concerns.

GP partner's described a major business strength of having a strong, cohesive staff team, and this was echoed by staff who described good team working within their areas. A number of staff had service in excess of 10 years, and there were regular team and social events with GPs and staff. There was a clear chain of command and organisational structure. Staff described the communication as generally good, although the practice recognised some difficulties in maintain multiple sites and managing these simultaneously.

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

There was an active Patient Participation Group (PPG), and action plans published on the practice website for the practice population to read. The group had a range of members of different ages and patient needs.

We saw some examples where the practice had worked with the PPG, including extended hours surgeries weekly on Mondays 6-30pm to 9-30pm alternating between Crowle and Skippingdale surgeries, telephone appointments and increased pre-bookable appointments in each surgery and for each GP. The PPG had also taken responsibility for the noticeboards in reception to improve patient information. The practice had signed up to the Productive General Practice programme, a CCG led innovation to encourage improvement and efficiencies. The practice had staged an open event about this which had been attended by the PPG. Members of the PPG also attended regional and NHS England meetings so were able to share ideas and best practice.

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

Are services well-led?

Good

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

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 necessary. We saw that appraisals took place where staff could identify learning objectives and training needs.

The practice had completed reviews of significant events and other incidents, and shared these with staff via team meeting discussions to ensure the practice improved outcomes for patients. Staff told us the culture at the practice was one of continuous learning and improvement.