Tall Trees Surgery

Quality Report

Retford Primary Care Centre
Retford Hospital, North Road
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Nottinghamshire
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Website: www.talltreesgpsurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tall Trees Surgery on 10 March 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

Our key findings across all the areas we inspected 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.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make appointments, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Patients reported appointment times sometimes never ran to schedule and they waited 15 minutes past their appointment time to be seen

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 and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had actively recruited new members to the patient participation group (PPG) which was merging with Bridegate Surgery. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Twelve percent of the practice population were over 75. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. These patients had access to a dedicated telephone number to contact the practice which was answered as a priority. Staff at the practice referred patients to support groups to help them maintain their independence.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. These patients also had access to the dedicated telephone number to contact the practice which was answered as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. 'Exercise on prescription' was available for patients whom would benefit from physical activity to support them managing their medical condition.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were

suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Practice nurses offered a confidential service providing contraceptive advice to teenagers via the C card scheme

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 age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening reflecting the needs for this age group.

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 held a register of patients living in such circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. Longer appointments were also offered for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All patients' experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advanced care planning for patients with dementia. The dementia diagnosis rate was above the national average and 92% of these patients had an annual review compared to the local average of 83%.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary

Summary of findings

organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 33 completed CQC comment cards and spoke with six patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

Patients were very satisfied with the service they received from the practice and this was aligned to the written feedback on the comment cards. Patients told us they were treated by staff with compassion, dignity and respect. Their health issues were discussed with them and they were involved in decision making about the care and treatment they received. They told us they felt listened too and all staff were very caring.

Five CQC comment cards contained less positive comments stating the GP sometimes rushed them. Patients told us the practice was always clean and tidy.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 and a survey of 120 patients undertaken by the practice manager. The evidence from these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. The practice was well above the CCG average for its satisfaction scores on consultations with nurses with 89% of practice respondents saying the nurse was good at listening to them and 93% saying the nurse gave them enough time. The GP scores were comparable with the CCG average with 88% of practice respondents saying the GP was good at listening to them and 87% saying the GP gave them enough time.

Reception scores were higher than the local and national average. For example:

- 95% of respondents to the national GP patient survey said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 86%.

The practice was well above the CCG average as 94% respondents describe their overall experience of this surgery as good compared to 89% locally. The practice was lower than the CCG average for waiting times in the practice as 41% of respondents reported they waited fifteen minutes or less after their appointment time compared to the CCG average of 74%.

Tall Trees Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

We also worked closely with the CQC inspection team undertaking the inspection at the neighbouring practice due to the shared functions and management arrangements at the two practices. This team was led by a CQC Lead Inspector and also included a GP specialist advisor.

Background to Tall Trees Surgery

Tall Trees Surgery is located in Retford. The practice provides services for approximately 5,365 patients under the terms of the locally agreed NHS Primary Medical Services contract. The practice catchment area is classed as within the group of the fifth less deprived areas in England. The age profile of the practice population is broadly similar to other GP practices in the Bassetlaw Clinical Commissioning Group (CCG) area.

The practice is situated within a purpose built health centre in Retford. There are three GP partners, two male and one female, who work at the practice. They are supported by two nurse practitioners, one practice nurse, one healthcare assistant, a team of administrative staff and a practice manager.

This practice is to merge with a neighbouring GP practice which is located in the same building. Preparations for the merger were underway and some administration functions were being shared at the time of the inspection. The managers and administration team of both practices had recently undergone changes to their role to support the merger.

The practice is open weekdays from 8am to 6.30pm with extended opening every Tuesday morning from 7.30am and extended closing on Tuesday and Thursday until 7pm. Minor surgery, diabetes, asthma, family planning, antenatal and mother & baby clinics are run each week. Out of hours care is accessed via the surgery telephone number or calling the NHS 111 service.

Tall Trees surgery is registered to provide; diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and the treatment of disease, disorder or injury from Retford Primary Care Centre, Retford Hospital, North Road, Retford, Nottinghamshire, DN22 7XF.

Why we carried out this inspection

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

Before visiting, we reviewed information we hold about the practice and asked Bassetlaw Clinical Commissioning Group (CCG) and NHS England to share what they knew. We carried out an announced visit on 10 March 2015. During our visit we spoke with two GPs, the practice manager, two nursing staff, one healthcare assistant and three members of the administrative team. We also spoke with six patients who used the service and reviewed 33 comment cards where patients shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records and incident reports. We were told they were discussed at practice meetings and the notes and actions were written by hand by the practice manager. We were told feedback to staff was cascaded via the practice manager to team managers.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. 'Significant events' was a standing item on the weekly practice meeting agenda. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they told us they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked nine incidents and saw records were completed in a timely manner. We saw evidence of action taken as a result. For example we were told how the procedure of administering medicines to patients had been reviewed and updated following an incident where a patient had requested and was given too much medicine. We saw notes the patient was informed of the error and informed of the correct dose of medicine. We saw a memo circulated to staff to remind them of prescribing guidelines.

National patient safety alerts were disseminated by the practice manager to practice staff via email and taken to the practice meeting. Staff we spoke with were able to give examples of recent alerts which were relevant to the care they were responsible for. Staff told us and we saw alerts were discussed at practice meetings and the actions were noted by the practice manager.

Reliable safety systems and processes including safeguarding

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

A GP partner was the lead for safeguarding vulnerable adults and children. They had been trained to level three for adults and children and could demonstrate they had the necessary skills. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. GPs were appropriately using the required codes on their electronic patient record system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead GP for safeguarding was aware of vulnerable children and adults records and demonstrated good liaison with partner agencies such as the police and social services. Practice staff attended children protection case conferences and

serious case reviews where appropriate. Reports were sent to the practice if staff were unable to attend. We were told about a referral made to social services by practice staff for a vulnerable person who required further support.

The practice held monthly multidisciplinary meetings which the health visitor, community paediatrician, community matron, palliative care team, pharmacist, physiotherapy and occupational therapists attended. Other health and social care staff attendance could be requested if needed. The practice had a procedure to follow up children who persistently failed to attend appointments at the practice which was actioned by the nursing staff.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Any changes in guidance about medicines were communicated to clinical staff by the practice manager. The information was then discussed with staff at meetings and further action taken if necessary. For example, in response to new guidance about a medicine we were told it had been discussed in a meeting which led to a review to identify the patients prescribed the medicine. This identified if any changes to patient prescriptions were required which could be subsequently actioned.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines which require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) which had been produced by the prescriber. We saw evidence the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to in accordance with the PSD from the prescriber. Two members' of the nursing team were qualified as independent prescribers and they received regular supervision and support in their roles' as well as updates in the specific clinical areas of expertise for which they prescribed.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. Reception staff told us the procedure for handling specimens from patients and they would use gloves and aprons if necessary. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual

updates. We saw evidence the lead had carried out audits for each of the last three years and any improvements identified for action were completed on time. Staff told us the infection control audit was discussed at practice meetings.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice manager told us the landlord was responsible for ensuring the water systems were checked. We were shown a monthly compliance report which was provided to the practice by the landlord and this showed the water systems had been tested in March 2015. In addition, we saw records which confirmed the practice also carried out regular checks to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks.

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 enough staff were 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 had started to share some of the management and administrative functions with another practice in preparation for the future merger. Staff told us this increased the resources within the administrative team and provided more office space.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We were told risks were reviewed at the practice meetings.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. Those patients considered high risk of hospital admission were given a dedicated telephone number to the practice which was answered as a priority. Practice staff told us how they monitored repeat prescribing for patients receiving medication for specific illnesses including mental health to ensure they did not receive too much of their medicine.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When

Good

Are services safe?

we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly. We checked the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included adrenaline (which can be used to treat anaphylaxis) and hydrocortisone (for treating asthma or recurrent anaphylaxis). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utility companies if power was lost.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We were told this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of stroke prevention.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records. This assisted the team to ensure the patients' needs were being met and assist in reducing the need for them to go into hospital. We observed the follow up process for patients who were being discharged from hospital in the high risk of hospital admission group. They were followed up within three days of discharge to ensure all their needs were continuing to be met. Staff at the practice kept a confidential log of patients' who were in hospital and those recently discharged so staff could refer to it on a daily basis. Staff told us this helped them track the patient as they could review admissions and discharges on the list rather than referring to the patient record.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last two years. Two of these were two cycle audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, following guidance from NICE about the care of patients' following a surgical procedure a clinical audit was carried out. The aim of the audit was to ensure all patients who had the procedure were aware of the need to have quick access to a medicine in the event of an infection. The first audit demonstrated one patient was not aware. The information was shared with GPs and the patient was called for a medication review. A second clinical audit was completed one year later which demonstrated all patients were aware.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

Good

Are services effective?

(for example, treatment is effective)

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98.6% of the total QOF target in 2014, which was above the national average of 94%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators were better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related QOF indicators was better than the national average.
- The dementia diagnosis rate was above the national average and 92% of these patients had an annual review compared to the local average of 83%.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting there was an expectation all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The electronic prescribing system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence after receiving an alert the GPs had reviewed the use of the medicine in question. Where they continued to prescribe they outlined the reason why they decided this was necessary in the patient notes.

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

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 area. This benchmarking data showed the practice had outcomes which were comparable to other services in the area. For example the number of patients' with a long term condition who were admitted to hospital as an emergency.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional diplomas in sexual and reproductive medicine, and one with an interest in sports medicine. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals and identified learning needs from which action plans were produced. Our interviews with staff confirmed the managers' were proactive in providing training and funding for relevant courses, for example a member of nursing staff was supported to complete a diploma in diabetes. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, and baby clinics. Those with extended roles who saw patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

The practice manager told us where poor performance had been identified appropriate action would be taken following the practice's policy. They told us they did not have any recent examples of when the policy had been used.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries were patients had not been followed up.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

We saw the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly review of follow-ups to ensure inappropriate follow-ups were documented and no follow-ups were missed. We were told they had not identified any inappropriate follow ups.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by March 2015. We were told they were on track to achieve this. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. This system also supported communication with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us 100% of care plans had been reviewed in last year). When interviewed, staff gave examples of how a patient's best

interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. Gillick competency tests are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 91% of patients over the age of 16 and actively offered smoking cessation clinics to 82% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Twelve percent of the practice population were over the age of 75. Each patient had a named GP and we were told they could be signposted to 'Staying Steady' programme run by the local hospital trust. This was an 8-week programme for patients who had fallen, or who were at risk of falling due to reduced mobility, strength and balance problems or general lack of confidence. The sessions focus on exercise and education.

The practice's performance for the cervical screening programme was 87%, which was above the national average of 77%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example: Flu vaccination rates for the over 65s were 74%, and at risk groups 58%. These were above national averages. We were told the practice nurse would visit patients in the local care home to administer the flu vaccine rather than the patient attending the surgery.

Staff at the practice also offered 'exercise on prescription' for patients whom would benefit from physical activity to support them managing their medical condition. One patient we spoke with told us how this had helped them become more physically active and improved the management of their condition.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015 and a survey of 120 patients undertaken by the practice's patient participation group (PPG) through satisfaction questionnaires. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was comparable to other practices in the area for its satisfaction scores on consultations with doctors. For example:

- 88% said the GP was good at listening to them compared to the CCG average of 89% and national average of 87%.
- 87% said the GP gave them enough time compared to the CCG average of 88% and national average of 85%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 92%

Nurse scores were higher than the local and national average. For example:

- 89% said the nurse was good at listening to them compared to the CCG average of 86% and national average of 79%.
- 93% said the nurse gave them enough time compared to the CCG average of 86% and national average of 80%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and national average of 85%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 33 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five CQC comment cards contained less positive comments stating the GP sometimes rushed them. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk behind a partition wall which helped keep patient information private. Additionally, 95% of respondents to the national GP patient survey said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 86%.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Staff told us how they booked some patients into appointments at times to meet the individual needs of the patient. For example booking a patient appointment during quieter periods in the practice or after school times.

Care planning and involvement in decisions about care and treatment

The information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. All of the

Good

Are services caring?

respondents to the PPG patient survey rated the practice as good or above for doctors and nurses explaining things to patients in a way they could understand. Respondents to the national GP patient survey were similar. For example:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 82%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 74%.
- 84% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 76%.
- 75% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 72% and national average of 66%.

Patients we spoke with on the day of our inspection told us their 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. Five CQC comment cards contained less positive comments stating the GP sometimes rushed them.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. We were also shown pictorial communication cards used by the GPs and nurses to support and communicate patients with learning difficulties and those whose first language was not English.

Patients with long term conditions told us they had agreed care plans which were reviewed as their care changed or at least once a year.

Patient/carer support to cope emotionally with care and treatment

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

- 86% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 82%.
- 88% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

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

Staff told us if families had experienced bereavement, their usual GP or nurse would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had continually looked to improve patient services and provided a dedicated telephone line for those patients with complex health needs which was answered as a priority. Practice nurses also held daily minor injury clinics which appointments could be booked on the day. Practice nurses offered a confidential service providing contraceptive advice to teenagers via the C card scheme. This scheme offers free contraception and advice for those young people registered with the service.

The NHS England Local Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements which needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A Text message reminder service had been introduced so patients could receive messages to their mobile phone to remind them of their appointment time and if their blood test and urine sample results were normal. Patients had to register with this service and we were told there had been a good uptake. Staff told us this also reduced the number of patients' who did not attend booked appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities or if a British sign language interpreter was required. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice occupied the second floor of the building and there was lift access. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 8am to 6.30pm on weekdays with extended opening and closing on Tuesday from 7.30am until 7pm and Thursday when it closed at 7pm. Appointments were available throughout the lunch period on Thursday.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term

Good

Are services responsive to people's needs?

(for example, to feedback?)

conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 77% were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 85% described their experience of making an appointment as good compared to the CCG average of 83% and national average of 73%.
- 96% said they could get through easily to the surgery by phone compared to the CCG average of 74% and national average of 84%.

The practice PPG survey reported patients' waited after their appointment time to be seen. This was echoed in the national GP patient survey as 41% of respondents said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 74% and national average of 65%. The practice manager told us they were actively looking at appointment times to identify where improvements could be made.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed those in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, a patient told us they were going on holiday and needed to see a GP before they went. They were given an appointment in the morning before they had to leave for the airport.

Home visits were available for those people with long-term conditions and they were also offered longer appointments if needed. Appointments were available outside of school hours for children and young people and the premises were suitable for children and young people. We were told practice staff worked closely with sexual health clinics and supported young people providing advice and contraceptives through the C Card scheme.

Patients reported the online booking system available was easy to use and they appreciated the text message reminder service for appointments and test results. They told us this prevented a further call to the practice for test results.

Staff at the practice told us how they supported people to return to work by referring to other health professionals such as physiotherapists and a 'Let's Talk Wellbeing' service run by the local hospital trust. This service provided a range of talking therapies for people who were experiencing common difficulties such as feeling low, anxious or stressed. The practice website contained information about and how to obtain 'fit notes'. Reception staff told us how they avoided booking appointments at busy times for people who may find this stressful.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system. Information was displayed in the waiting area and summarised in the practice complaints leaflet available in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at eight complaints received in the last 12 months and found these were handled satisfactorily and dealt with in a timely way. The response letters contained some detail and transparency dealing with the complaint and contained an apology where necessary. We noted and fed back to the practice manager response letters should include details of the parliamentary and health service ombudsman for the complainant to pursue further if they felt necessary.

The practice reviewed complaints annually to detect themes or trends. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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 vision to deliver high quality care and promote good outcomes for patients. The practice aims and objectives included the aim to put patients at the heart of everything they do. Our discussions with staff and patients indicated the vison and values were embedded within the culture of the practice. Staff told us they were well supported.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at seven of these policies and procedures had been reviewed annually and were up to date. We noted the practice nurses did not have a protocol for requesting x-ray. This was fed back to the practice manager.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice nurse told us how they took an active leadership role overseeing the systems in place to monitor the quality of the service provided to patients'. This included using the Quality and Outcomes Framework to measure its performance. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice used the QOF data to measure its performance. The data for this practice showed it was performing in line with or above national standards and the practice had achieved almost maximum QOF points at 98.6% which was above the CCG average of 94.2%.

The practice was working together with another practice and they were in the process of developing some shared governance functions such as human resources and administration prior to the formal merger of both practices.

The management structure was going through a period of change and the practice manager had just been recruited to manage both practices. The managers we spoke with were clear about the plans and changes taking place.

We were told by the GP partner the practice had a five business year plan relating to the merger of the practices which had two years left to run.

Staff at the practice demonstrated evidence clinical audits were used to monitor quality and to identify where action should be taken. We noted there was no planned schedule of clinical audit.

The practice had arrangements for which identified, recorded and managed risks. Risk assessments had been carried out. Where risks were identified action plans had been produced and implemented.

Leadership, openness and transparency

Staff told us they were supported in their work opportunities for staff to meet for discussion or to seek support and advice from colleagues.

The practice held regular staff meetings. We were told there was an open culture and staff had the opportunity and were happy to raise issues at team meetings. The staff also told us they had protected learning time and felt supported in their learning.

Patients could access a number of policies and procedures on the practice website and within the practice. For example, procedures relating to complaints, confidentiality and freedom of information were available.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The practice PPG was merging with the other practice and recruiting new members which included representatives from various population groups; over 75's, long term conditions.

The PPG had carried out annual surveys. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website and on a notice board in the practice. We spoke with two new members of the PPG and

Are services well-led?

Good

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

they were very positive about the role and told us they felt engaged with the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Staff feedback was gathered at regular practice meetings and through annual appraisals. Staff told us they felt comfortable approaching any of the management team.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had been able to develop their skills and knowledge.

The practice had completed reviews of significant events and other incidents and shared the information with staff at meetings to ensure the practice improved outcomes for patients. For example, significant events were reviewed during a weekly multidisciplinary meeting and non-clinical issues were discussed at the weekly staff meetings.