The Beggarwood Surgery

Quality Report

Broadmere Road
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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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Beggarwood Surgery on 31 May 2016. Overall the practice is rated as requires improvement.

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.
- Risks to patients were assessed and managed. However, reviews and investigations were not thorough enough.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- Information about services and how to complain was available and easy to understand.
- Patients with long term conditions and mental health diagnoses had a named GP for continuity of care.
- Telephone consultations were available and urgent appointment were the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Policies and procedures were in place to support staff to carry out their role. These were not sufficiently embedded to ensure systems and processes in place worked effectively to mitigate risk and drive improvement.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.
- The practice was aiming to become a highly performing organisation with a focus on patient care. There had been a period of instability and staff teams had changed significantly over the previous two years. The provider acknowledged during the inspection that although systems and processes were in place to support staff, they needed to be confident the staff would work as a cohesive team to drive improvement in the practice.

Summary of findings

The areas where the provider must make improvement are:

- Ensure systems in place to monitor effectiveness, quality and safety of the practice are sufficiently embedded and used to mitigate the risk of harm to patients and drive improvement. In particular: complaints handling; significant event management and clinical audits. Ensure learning points identified as a result of complaints or significant events are acted on and monitored and include reference to the Duty of Candour when identified.
- Ensure when health and safety assessments are carried out remedial action is taken in a timely manner, with regard to electrical wiring.
- Ensure records related to the running of the practice are suitably maintained, up to date and accurate. This includes recruitment and training records and those related to the safety of patients, such as fire drills.

The areas where the provider should make improvement are:

- Review systems to ensure that appraisals for all staff are carried out in accordance with the practice policy.
- Review systems for managing significant events.
- Review systems for obtaining and recording consent prior to invasive procedures.

Professor Steve FieldCBE 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 responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Infection control and cleaning schedules in the practice made sure that patients were treated in a safe and hygienic environment.
- Medicines were handled safely and prescriptions were stored securely and their use monitored.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below or comparable to the national average. The practice had implemented strategies to engage patients in their health checks to improve outcomes.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Improvements were needed in the recording of training to demonstrate that it had been planned for and delivered.
- There was evidence of appraisals and personal development plans for all staff, but improvements were needed to ensure all staff received appraisals at appropriate intervals.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. Where areas for improvement had been identified from patients' surveys, the practice had commenced a targeted patient survey to gather further information to inform them of what improvements were needed. The survey was due to closed in July 2016.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and ClinicalCommissioning Group to secure improvements to services where these were identified. The practice worked with the North Hampshire Alliance for GPs to secure phlebotomy services for practices within this group.
- Patients with long term conditions and mental health diagnoses had a named GP to provide continuity of care.
- Comment cards received showed that nine out of 26 patients said that it was not always easy to make a routine appointment. The practice had reintroduced telephone consultations to enable access and 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. However, there was limited evidence that learning from complaints had been shared fully with relevant staff and action had been taken to resolve concerns to the complainant's satisfaction.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- All staff had received inductions but not all staff had received regular performance reviews.
- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- 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.
- Systems were in place to monitor the effectiveness and safety of the practice, but these were not sufficiently robust to ensure a comprehensive understanding of the performance of the practice was maintained. We found that complaints and significant events meetings did not fully demonstrate how concerns and incidents were being managed in a manner which mitigated risk and ensuring learning points identified were actioned.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements, but this was not effectively joined up, so that clinical audits carried out by all GPs, were being used to drive improvement in the practice.
- Records required for the running of the practice were not readily available on the day and we found that there were different locations for related records. For example, training records were a mixture of paper based and computer held records; there was no overarching training programme in place, which demonstrated when training was due; when it had been given; and what future training had been planned for.
- Systems and processes in place for appraising staff did not ensure that they had received appropriate support.
- The practice was aiming to become a highly performing organisation with a focus on patient care. There had been a period of instability and staff teams had changed significantly over the previous two years. The provider acknowledged during the inspection that although systems and processes were in place to support staff, they needed to be confident the staff would work as a cohesive team to drive improvement in the practice.

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

Requires improvement

The provider was rated as requires improvement for effective, responsive and for well-led and good for safe and caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- All older patients had a named GP to provide continuity of care, which enabled patients to speak to a clinician within 24 hours when needed.
- Contact details for community support workers, carers and relatives were recorded in patient records.

The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for effective, responsive and for well-led and good for safe and caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients on the diabetes register who had had their average blood glucose levels monitored over three months was 77%, compared with the clinical commissioning group (CCG) average of 78% and the national average of 77%. A total of 84% of patients on the diabetes register had had a foot examination in the preceding 12 months, compared with the CCG average of 81% and the national average of 80%.
- 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 medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

- The practice provided newly diagnosed patients with information on how to manage their condition and offered further support when needed.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for effective, responsive and for well-led and good for safe and caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- 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. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Children aged under five were either seen or the person with parental responsibility were contacted by telephone within four hours of a request being made.
- The practice's uptake for the cervical screening programme was 80%, which was higher than the CCG average of 75% and the national average of 74%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

The practice had separate male and female accessible toilets and the baby changing facilities were in a separate room from toilets.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for effective, responsive and for well-led and good for safe and caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- 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.
- Pre-bookable telephone appointments were available for working patients.

Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for effective, responsive and for well-led and good for safe and caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those with a learning disability.
- Patients who were part of the travellers' community were able to register with the practice for healthcare and the practice was aware of health priorities that such communities may have, for example, needing to see a health professional as quickly as possible when children were sick.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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.
- Patients who were unable to read and write well were assisted by staff to complete forms when needed.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for effective, responsive and for well-led and good for safe and caring. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Patients with these conditions had a named GP to provide continuity of care.
- Performance for mental health related indicators was better than the national average.For example, 100% of patients with

schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented, compared with the CCG average of 94% and the national average of 88%.

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice carried out advance care planning for patients living with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Contact information for self-referrals to mental health services was displayed in the practice.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and those living with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published January 2016. The results showed the practice was performing in line with local and national averages. A total of 274 survey forms were distributed and 113 were returned. This represented 2% of the practice's patient list.

- 88% of patients found it easy to get through to this practice by phone compared to the CCG average of 77% and the national average of 73%.
- 74% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 78% and the national average of 76%.
- 85% of patients described the overall experience of this GP practice as good compared to the CCG average of 89% and the national average of 85%.
- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 85% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards which were all positive about the standard of care received. There were some negative comments on the availability of routine appointments, with two patients saying they would appreciate Saturday morning appointments and evening appointments. Two comments related to reception staff who were perceived as being abrupt. Positive comments included staff being friendly, professional and willing to help. Patients said they were treated with respect and gave good advice. When patients had treatment plans in place these had been discussed with them. One comments highlighted improvements in service due to the telephone triage situation being resumed.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The most recent results from the Family and Friends test showed that 71% were extremely likely to recommend the practice and 14% were likely to recommend the practice to others. The practice had incorporated this question into their patient survey which was due to end in July 2016, as they wanted to improve the results.

The Beggarwood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.**The team included a GP specialist adviser, and a practice manager specialist adviser.

Background to The Beggarwood Surgery

The Beggarwood Surgery is situated in a residential area of Basingstoke. The practice is part of Cedar Medical Group Limited, whose parent company is Integral Medical Holdings.

The Beggarwood Surgery has approximately 7400 patients registered. The practice had a higher number of patients aged 35 to 49 years old; and 0 to 14 years of age when compared with the national average. Approximately 13% of the practice population identified themselves as of Ethnic origin, which included Polish, Asian and African.

All GPs who work at the practice are salaried. In total there are five GPs; one male GP and four female GPs. The GPs work a total of 30 sessions per week, which is equivalent to 3.75 whole time equivalent GPs. The practice has recently employed a pharmacist, who was also a prescriber, to manage prescriptions and medicines. One nurse practitioner, three practice nurses and one healthcare assistant make up the nursing team. Clinical staff are supported by an operational manager; a practice manager and a team of administration and reception staff.

The practice was open between 8.30am and 6pm Monday to Friday. Appointments were available from 9am to 12 or 12.30pm every morning and 3pm to 5.30pm daily apart from Tuesday afternoons when appointments were available from 1.30pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. When the practice was closed patients were requested to contact the out of hours GP service via the NHS 111 service.

We inspection the only location:

The Beggarwood Surgery

Broadmere Road

Basingstoke

Hampshire

RG22 4AG

This was the first inspection for the practice.

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. The 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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 31 May 2016. During our visit we:

- Spoke with a range of staff which included GPs, nurses, the practice manager and reception staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public 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 athow well services were provided for specific groups of people and what good care looked 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 living with dementia).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out an analysis of the significant events. We found that significant events were not consistently documented fully to show what learning actions were needed. The records did show that all significant events were discussed in clinical meetings; however, there was a significant gap in the significant event folder from 2013 to 2016, prior to Integral Medical Holdings taking over the practice. Records maintained did not give an accurate and full overview of significant events identified; how these were managed and what learning and/or changes had been made as a result of an incident.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3.
- The practice's safeguarding team met on a quarterly basis to discuss any safeguarding concerns.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. 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. All patients were offered a chaperone and these were only nurses or health care assistants who had completed the necessary training.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, and their own pharmacist, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The nurse practitioner and pharmacist had qualified as an Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role.

Good

Are services safe?

- Blank prescription forms and pads were usually securely stored and there were systems in place to monitor their use. Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice had had a five yearly electrical wiring check carried out in 2011, but there were no records that areas needing work following this check had been completed. The practice immediately arranged for a further full electrical wiring check to be carried out within a week of our inspection.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15, published in October 2015 showed:

- Performance for diabetes related indicators was similar to the national average. For example, the percentage of patients on the diabetes register who had had their average blood glucose levels monitored over three months was 77%, compared with the clinical commissioning group (CCG) average of 78% and the national average of 77%. A total of 84% of patients on the diabetes register had had a foot examination in the preceding 12 months, compared with the CCG average of 81% and the national average of 80%.
- The number of patients with diabetes on the register who had had a flu vaccination was 99%, compared with the CCG average of 95% and national average of 94%.We noted that exception reporting for this aspect of the domain was significantly higher that CCG and national averages; at 30%; compared with 18% CCG and 18% national averages. The practice said that they had taken action and sent three recall letters inviting patients to receive the flu vaccine. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- Performance for mental health related indicators was better than the national average. For example, 100% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented, compared with the CCG average of 94% and the national average of 88%.
- There was evidence of quality improvement including clinical audit.We looked at a sample of clinical audits which had been completed over the past two years. Two of these were completed audits where the improvements identified were acted upon and monitored. For example, one audit was carried out to identify patients who were potentially at risk of developing diabetes. Patients who were identified had a condition known as polycystic ovary syndrome and who had raised body mass index. In January 2015 a data search was carried out on patient records to identify those at risk. Results showed that 10 out of the 28 patients identified had had a blood test in the preceding two years, to test for diabetes. Alerts were then placed on all patients' records that were deemed to be at risk.
- In August 2015 the second cycle of the audit was carried out. Results from the second audit showed that 25 patients had been identified and 16 of them had had a blood test carried out. This had resulted in one new case of diabetes being diagnosed. The practice were disappointed that four patients had been seen during this time period, but had not been offered blood tests. Findings were used by the practice to improve services; the practice sent letters to all patients who they had identified as being at risk, inviting them to have a blood test to check for diabetes.
- However, the practice did not have a comprehensive system in place for collating all audits that GPs had undertaken. The practice did not have an overarching audit plan which included practice specific audits.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

Effective staffing

Requires improvement

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Newly employed GPs had a comprehensive induction programme; time for this was protected, so they had sufficient time to learn how staff in the practice worked as a whole.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The practice had lead GPs and nominated nurses responsible for asthma reviews and diabetic reviews. The nursing staff had received appropriately training to carry out this role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. The practice manager said that none of the reception and administrative staff had received an appraisal in the past 12 months. One file we looked at showed that a member of reception staff had not had an appraisal since 2013. Dates had been identified to ensure this was completed as soon as practicable and no later than 22 July 2016, records we saw confirmed this. The remainder of staff had received an appraisal within the last 12 months.
- Established staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Records demonstrated that not all staff had received training on areas such as safeguarding, basic life support and information governance. These were considered to be mandatory by the practice. Training had started to be carried out via an online system, which was replacing the paper based system. Staff files we looked at had some details of training provided. We found that two members of staff had not received basic life support training; one nurse had not received training on safeguarding children; and information governance training had not been undertaken by two members of staff. The practice was unable to clarify what training had been carried out on the online system.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Requires improvement

Are services effective?

(for example, treatment is effective)

- We found that the practice did not routinely obtain written consent for contraceptive procedures, such as long acting contraceptive implants. When a patient had this procedure a checklist was completed, but the patient did not sign a consent form, which detailed the risks associated with the procedure.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were offered support, or signposted to the relevant service.

The practice's uptake for the cervical screening programme was 80%, which was higher than the CCG average of 75% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. A total of 79% of females aged 50 to 70 years old had been screened for breast cancer in the last three years. This compares with the CCG and national average of 72%. A total of 63% of patients eligible had been screened for bowel cancer in the last two and a half years, compared with the CCG average of 62% and national average of 58%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccines given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 50% to 98%% and five year olds from 93% to 99%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15, published in October 2015 showed:

- Performance for diabetes related indicators was similar to the national average. For example, the percentage of patients on the diabetes register who had had their average blood glucose levels monitored over three months was 77%, compared with the clinical commissioning group (CCG) average of 78% and the national average of 77%. A total of 84% of patients on the diabetes register had had a foot examination in the preceding 12 months, compared with the CCG average of 81% and the national average of 80%.
- The number of patients with diabetes on the register who had had a flu vaccination was 99%, compared with the CCG average of 95% and national average of 94%.We noted that exception reporting for this aspect of the domain was significantly higher that CCG and national averages; at 30%; compared with 18% CCG and 18% national averages. The practice said that they had taken action and sent three recall letters inviting patients to receive the flu vaccine. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- Performance for mental health related indicators was better than the national average. For example, 100% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented, compared with the CCG average of 94% and the national average of 88%.
- There was evidence of quality improvement including clinical audit.We looked at a sample of clinical audits which had been completed over the past two years. Two of these were completed audits where the improvements identified were acted upon and monitored. For example, one audit was carried out to identify patients who were potentially at risk of developing diabetes. Patients who were identified had a condition known as polycystic ovary syndrome and who had raised body mass index. In January 2015 a data search was carried out on patient records to identify those at risk. Results showed that 10 out of the 28 patients identified had had a blood test in the preceding two years, to test for diabetes. Alerts were then placed on all patients' records that were deemed to be at risk.
- In August 2015 the second cycle of the audit was carried out. Results from the second audit showed that 25 patients had been identified and 16 of them had had a blood test carried out. This had resulted in one new case of diabetes being diagnosed. The practice were disappointed that four patients had been seen during this time period, but had not been offered blood tests. Findings were used by the practice to improve services; the practice sent letters to all patients who they had identified as being at risk, inviting them to have a blood test to check for diabetes.
- However, the practice did not have a comprehensive system in place for collating all audits that GPs had undertaken. The practice did not have an overarching audit plan which included practice specific audits.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

Effective staffing

Good

Are services caring?

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Newly employed GPs had a comprehensive induction programme; time for this was protected, so they had sufficient time to learn how staff in the practice worked as a whole.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The practice had lead GPs and nominated nurses responsible for asthma reviews and diabetic reviews. The nursing staff had received appropriately training to carry out this role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. The practice manager said that none of the reception and administrative staff had received an appraisal in the past 12 months. One file we looked at showed that a member of reception staff had not had an appraisal since 2013. Dates had been identified to ensure this was completed as soon as practicable and no later than 22 July 2016, records we saw confirmed this. The remainder of staff had received an appraisal within the last 12 months.
- Established staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Records demonstrated that not all staff had received training on areas such as safeguarding, basic life support and information governance. These were considered to be mandatory by the practice. Training had started to be carried out via an online system, which was replacing the paper based system. Staff files we looked at had some details of training provided. We found that two members of staff had not received basic life support training; one nurse had not received training on safeguarding children; and information governance training had not been undertaken by two members of staff. The practice was unable to clarify what training had been carried out on the online system.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

- We found that the practice did not routinely obtain written consent for contraceptive procedures, such as long acting contraceptive implants. When a patient had this procedure a checklist was completed, but the patient did not sign a consent form, which detailed the risks associated with the procedure.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

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The practice's uptake for the cervical screening programme was 80%, which was higher than the CCG average of 75% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. A total of 79% of females aged 50 to 70 years old had been screened for breast cancer in the last three years. This compares with the CCG and national average of 72%. A total of 63% of patients eligible had been screened for bowel cancer in the last two and a half years, compared with the CCG average of 62% and national average of 58%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

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Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice worked closely with the North Hampshire alliance of GPs to meet the needs of patients. For example, they had successfully bid for phlebotomy services to be provided in GP practices in the area.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. Comment cards we received included very positive comments about children being seen as a priority.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately or were referred to other clinics for vaccines when needed.
- There were disabled facilities, a hearing loop and translation services available. The practice had separate male and female accessible toilets and the baby changing facilities were in a separate room from toilets.
- Patients who were unable to read and write were assisted by staff to complete forms when needed.
- Patients who were part of the travellers' community were able to register with the practice for healthcare and the practice was aware of health priorities that such communities may have, such as, needing to see a health professional as quickly as possible when children were sick.

Access to the service

The practice was open between 8.30am and 6pm Monday to Friday. Appointments were available from 9am to 12 or 12.30pm every morning and 3pm to 5.30pm daily apart from Tuesday afternoons when appointments were available from 1.30pm. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them. When the practice was closed patients were requested to contact the out of hours GP service via the NHS 111 service.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 69% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 88% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice used a telephone consultations system, which allowed patients to speak with a GP, nurse or the pharmacist to receive treatment advice. If needed the healthcare professional would arrange for a patient to be seen face to face.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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 that information was available to help patients understand the complaints system.
- We looked at 14 complaints received in the last 12 months and found that records did not fully demonstrate whether the process had been followed

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

and whether the matter had been resolved satisfactorily. The complaints policy was displayed on the website and leaflets were available from the reception.

- All complaints were reviewed in monthly clinical meetings, but learning and/or action points were not recorded. We looked at two complaints which were reliant on information from telephone consultations with patients and were opened and resolved quickly without clear information being available as to whether the patient was satisfied with the response.
- One complaint was received on 21 October 2015 and closed the following day. The other complaint was received on 11 February 2016 and resolved on 15 February 2016. The responses were not customer focused and relevant information was not routinely scanned into patient records. For example, copies of complaints letters received and sent as evidence to support the investigation had been carried out. One of these complaints was reliant on a discussion a GP had with a patient on the telephone. The practice routinely recorded all telephone conversations for audit and training purposes. However, the telephone recordings from this complaint could not be found.

The practice had commenced putting all complaints onto their computer system to facilitate recording and monitor outcomes for patients.**Responding to and meeting people's needs**

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Requires improvement

Are services responsive to people's needs?

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Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The Beggarwood Practice is part of Cedar Medical Limited which is part of Integral Medical Holdings group consisting of GP practices, Urgent Care and Walk-in centres. The organisation had a clear mission statement 'To improve the health, well-being and lives of those we care for.' Aims and objectives for GP practices included providing high quality, safe and professional services and to work in partnership with patients. The vision included being the leading GP practice in Basingstoke.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The practice had policies and procedures in place and these were being transferred onto the computer system to enable easy access and to provide a web based depository for all GP practices within the group. We reviewed the policies which had been signed off in November 2015. We found that there were version controls and dates for review. However, we noted that some policies contained information from other policies. For example the policy on vaccine management and cold chain standards had information about notifying the Care Quality Commission about serious injury to a patient that used the service.
- Systems were in place to monitor the effectiveness and safety of the practice, but these were not sufficiently robust to ensure a comprehensive understanding of the performance of the practice was maintained. We found that complaints and significant events meetings did not fully demonstrate how concerns and incidents were being managed in a manner which mitigated risk and ensuring learning points identified were actioned. For example, meeting minutes and significant event analysis did not routinely identify any themes or trends and there was no monitoring of any actions points identified.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements, but this was not effectively joined up, so that clinical audits carried out by all GPs, were being used to drive improvement in the practice.
- Records required for the running of the practice were not readily available on the day and we found that there were different locations for related records. For example, the Legionella risk assessment had identified that weekly water temperature checks were needed. The records for these checks were held in a different folder. Training records were a mixture of paper based and computer held records; there was no overarching training programme in place, which demonstrated when training was due; when it had been given; and what future training had been planned for. Files for GP recruitment were held in paper form and on the computer system and these had not been cross referenced to show where information was held. Induction checklists had not been completed fully.
- Systems and processes in place for appraising staff did not ensure that they had received appropriate support. We found that reception and administration staff had not had an appraisal in the preceding year and one member of this team had not had an appraisal since 2013.
- Fire drills had been carried out but not recorded fully. We found that no dates were recorded and there was only a list of staff present at the fire drill.

Leadership and culture

On the day of inspection staff in the practice demonstrated they had the experience, capacity and capability to run the practice. They told us they prioritised safe, high quality and compassionate care. Staff told us GPs were approachable and always took the time to listen to all members of staff. Staff also said that the organisation supported them.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of

Are services well-led?

Requires improvement

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

candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). However, lack of a robust system for managing significant events did not fully mitigate the risk of a breach in the duty of candour being identified.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings; these included monthly clinical meetings, nurses meetings. External meetings were also held with health visitors on a quarterly basis and the clinical commissioning group bi-monthly.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- GPs considered they were well supported and worked for a well led organisation.
-
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG was in a virtual format and had 29 members, who age ranged from 25-79 years old. The practice said that they were promoting the virtual group and were seeking to have an active PPG group which met face to face. This was due to limited response from the virtual group.
- The practice had looked at responses from the NHS GP Patient Survey and were in the process of determining an action plan to address concerns, particularly those around appointment availability and access.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

The practice was aiming to become a highly performing organisation with a focus on patient care. There had been a period of instability and staff teams had changed significantly over the previous two years. The provider acknowledged during the inspection that although systems and processes were in place to support staff, they needed to be confident the staff would work as a cohesive team to drive improvement in the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have appropriate systems, processes and policies in place to manage and monitor risks to the health, safety and welfare of patients, staff and visitors to the practice. The registered person did not have systems in place to ensure they were able to maintain an accurate and complete record in respect of each service user at all times. • Systems in place to monitor effectiveness, quality and safety of the practice were not sufficiently embedded and used to mitigate the risk of harm to patients and drive improvement. In particular: significant event management and clinical audits. • Learning points identified as a result of complaints or significant events were not fully acted on and monitored. • Remedial action in response to health and safety assessments were not carried out in a timely manner, in particular those related to electrical wiring. • Records related to the running of the practice were not suitably maintained, up to date and accurate. This included recruitment and training records and those related to the safety of patients, such as fire drills. This was in breach of regulation 17 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	The registered provider did not have suitable systems in place to ensure staff were suitability competent and skilled to carry out their role. Arrangements for appraising staff did not support staff to carry out their duties. None of the reception or administration staff had received an appraisal within the last 12 months as required in the practice policy. Established staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Records demonstrated that not all staff had received training on areas such as safeguarding, basic life support and information governance. These were considered to be mandatory by the practice. We found that two members of staff had not received basic life support training; one nurse had not received training on safeguarding children; and information governance training had not been undertaken by two members of staff. The practice was unable to clarify what training had been carried out on their online system. This was in breach of regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have suitable systems in place to act on complaints received. This was in breach of regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. • We looked at 14 complaints received in the last 12 months and found that records did not fully demonstrate whether the process had been followed and whether the matter had been resolved satisfactorily

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Requirement notices

- All complaints were reviewed in monthly clinical meetings, but learning and/or action points were not recorded. We looked at two complaints which were reliant on information from telephone consultations with patients and were opened and resolved quickly without clear information being available as to whether the patient was satisfied with the response.
- The responses were not customer focused and relevant information was not routinely scanned into patient records. For example, copies of complaints letters received and sent as evidence to support the investigation had been carried out. One of these complaints was reliant on a discussion a GP had with a patient on the telephone. The practice routinely recorded all telephone conversations for audit and training purposes. However, the telephone recordings from this complaint could not be found.