

Belgrave Surgery

Quality Report

Lawrence House Medical Centre
1 Belgrave Crescent
Scarborough
YO11 1UB
Tel: 01723 361279
Website: www.belgravesurgery.co.uk

Date of inspection visit: 04/11/2014
Date of publication: 22/01/2015

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

Ratings

Overall rating for this service

Good 

Are services safe?

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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9
Outstanding practice	9

Detailed findings from this inspection

Our inspection team	10
Background to Belgrave Surgery	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Belgrave Surgery on 4 November 2014.

We rated the practice overall as Good.

Our key findings were as follows:

- Staff reported incidents and learning took place. The practice had enough staff to deliver the service. Services were delivered using evidence based practice.
- Staff were caring and compassionate. Patients told us they were treated with dignity and respect.
- The practice was responsive to the needs of patients and took into account any comments, concerns or complaints to improve the practice.
- The practice was well led, with an accessible and visible management team with clear direction. Governance systems and processes were in place and quality management information was available and used to improve outcomes for patients.

We saw two areas of outstanding practice including:

- The practice was linked with Scarborough University Campus. The practice staff attended Fresher's week at the University where they offered on campus health assessments for students who wished to register. Students were provided with health information packs. Health and well-being events also took place at the University throughout the year and the practice worked in conjunction with the University Counselling Service.
- Clinical and reception staff had used their initiative when they had raised a concern about a vulnerable patient to other agencies which led to a positive outcome for the patient. The practice had been commended by the Domestic Abuse Team.

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

Importantly, the provider should:

- Ensure that all emergency medication is within its expiry date.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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 people safe.

Good



Are services effective?

The practice is rated as good for effective. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff considered and implemented guidance from the National Institute for Health and Care Excellence (NICE). Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams and with other practices.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said staff listened, were helpful, supportive and caring. They said staff treated them with dignity and respect. Information was made available to patients to sign post them to other support services and organisations. We were told by the practice of two specific examples which highlighted the practices caring ethos and attitude towards its patients. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS 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; although this was not always with the preferred GP. Urgent appointments were available the same day and home visits and telephone consultations made available where required.

Good



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 that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

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 patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice is rated as good for the care of 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over 75 years of age had a named GP and a care plan. The practice had identified all patients who were Veterans. The practice had recently recruited a nurse practitioner who they planned would lead on the care of the over 75 year olds and to work with residential and nursing homes to reduce A&E admissions. Immunisations were offered to this group of patients; for example shingles. Immunisation rates were equal to the national average for flu vaccines in patients over 65 years.

Good



People with long term conditions

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Clinical staff specialised in areas such as Heart Failure, chronic obstructive pulmonary disease (COPD), Diabetes and Asthma. The practice offered specific nurse led clinics for patients with long-term conditions. The practice had an effective recall system in place. Nationally reported data showed the practice was proactive in identifying and monitoring patients with long-term conditions.

Good



Families, children and young people

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 who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered a full range of immunisations for children. Immunisation rates of children who were eligible for immunisations at aged 12 months that received immunisations was slightly below the CCG average and the percentage of children aged 24 months and 5 years who were eligible for immunisations that receive immunisations and at 24 months and aged 5 years was slightly above the CCG average.

Appointments were available outside of school hours. The premises were suitable for children and babies. The practice worked jointly with the community midwife and health visitor; with both being

Good



Summary of findings

based at the practice. The practice had two trained GPs who offered regular contraception clinics and sexual health advice. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

The practice is rated as outstanding for the population group 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 offered extended appointments from 8am to 8pm Monday to Friday in partnership with Falsgrave Surgery. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice was linked with Scarborough University Campus. The practice staff attended Fresher's week at the University where they offered on campus health assessments for students who wished to register. Students were provided health information packs. Health and well-being events also took place at the University throughout the year and the practice worked in conjunction with the University Counselling Service.

Outstanding



People whose circumstances may make them vulnerable

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and carried out annual health checks for these patients either at the practice or in their home. Easy read literature was made available for patients; for example when having a cervical smear. The practice also offered longer appointments for people with a learning disability. The practice held a register of vulnerable patients who may be at risk of unplanned admissions. All these patients had a care plan in place.

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.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The number of patients experiencing poor mental health who had received an annual physical health check was higher than the national average. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health; for example the Addictive Behaviour Service (ABS) and Primary Care Mental Health Worker (CAMHS). Patients could access this service at the practice on a weekly basis. The practice 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. The practice worked with the University Counselling Service to utilise their services.

Good



Summary of findings

What people who use the service say

We spoke with three patients who were using the service on the day of our inspection, two members of the patient participation group (PPG) and reviewed 33 completed CQC comment cards. The majority of feedback from patients was positive. Patients described the practice as excellent; helpful and caring.

National GP survey results published in July 2014 indicated that the practice was best in the following areas:

- 88% of respondents usually waited 15 minutes or less after appointment time to be seen - CCG (regional) average: 72%
- 94% of respondents found it easy to get through to this surgery by phone - CCG (regional) average: 81%
- 88% of respondents were satisfied with the surgery's opening hours - CCG (regional) average: 81%

The national GP survey results published in July 2014 indicated that the practice could improve in the following areas:

- 82% of respondents said the last GP they saw or spoke to was good at treating them with care and concern - CCG (regional) average: 89%
- 87% of respondents said the last GP they saw or spoke to was good at listening to them – CCG (regional) average: 91%
- 64% of respondents with a preferred GP, usually got to see or speak to that GP - CCG (regional) average: 68%

There were 321 surveys sent out, 119 returned giving a completion rate of 37%.

Areas for improvement

Action the service **SHOULD** take to improve

Ensure that all emergency medication within GPs bags are within their expiry date.

Outstanding practice

The practice was linked with Scarborough University Campus. The practice staff attended Fresher's week at the University where they offered on campus health assessments for students who wished to register. Students were provided health information packs. Health and well-being events also took place at the University throughout the year and the practice worked in conjunction with the University Counselling Service.

Clinical and reception staff had used their initiative when they had raised a concern about a vulnerable patient to other agencies which led to a positive outcome for the patient.

Belgrave 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 and a practice manager.

Background to Belgrave Surgery

Belgrave Surgery, Lawrence House Medical Centre, 1 Belgrave Crescent, Scarborough, YO11 8RZ is situated in Scarborough town centre. The registered patient list size of the practice is 4,935 of which 2,436 are male and 2,499 are female. The overall practice deprivation is higher than the England average.

There are two GP partners and two salaried GPs. The clinical team is made up of a senior practice nurse, a practice nurse and two health care assistants. There is practice manager, deputy practice manager, administration team manager and a range of administration staff.

Belgrave Surgery is a GP training practice.

The practice has a general medical service (GMS) Contract under section 84 of the National Health Service Act 2006. The NHS Commissioning Board and the practice enter into a general medical services contract under which the practice is to provide primary medical services and other services in accordance with the provisions of the Contract.

The practice has opted out of providing out-of-hours services to their own patients. Patients use the 111 service when the practice is closed. Patients are seen by Primecare out of hours.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Detailed findings

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)

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 4 November 2014. During our visit we spoke with a range of staff; GP partner, salaried GP, senior practice nurse, practice nurse, health care assistant, practice manager, deputy practice manager and an administrator. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included systems for reporting incidents, acting on national patient safety alerts, recalling patients to the practice as well as responding to comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible. We were provided with an example where the practice had been commended by the Domestic Abuse Team for swift action the practice had taken to protect a patient.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We were shown records of significant events that had occurred during the last 12 months. Records showed significant events were regularly discussed at practice meetings. There was evidence that the practice had learned from significant events and the findings were shared with relevant staff and learning identified and actioned. All staff knew how to raise an issue for consideration at practice meetings and felt confident and encouraged to do so.

We were shown the system used to manage and monitor incidents. We tracked 12 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example the process of managing test results had been revisited with staff following an incident. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were

able to give examples of recent alerts that were relevant to the care they were responsible for. We saw examples of action the practice had taken in response to safety alerts. They also told us alerts were discussed at practice meetings and information disseminated to staff who were not present at the meetings. The practice had recently initiated clinical meetings for all clinical staff to attend as this had previously not been in place. The practice had recognised the need to ensure all staff attended clinical meetings to ensure they were aware of any relevant issues and guidance and any action that needed to be taken.

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 which showed that 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.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained to Level 3 and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware of the lead and who to speak to 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. Staff told us about the systems they had in place for monitoring vulnerable patients. For example; identifying children with a high number of A&E attendances and following up children who failed to attend appointments for childhood immunisations.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All clinical and non-clinical staff had been trained to be a chaperone.

Are services safe?

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were found to be stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures and the action to take in the event of a potential failure. The temperature of the fridges, used specifically for the storage of medicines and vaccines, were regularly checked and recorded. The cold chain process of keeping medicines within the correct temperature range was followed by staff.

Processes were in place to check medicines stored in the treatment rooms and refrigerators were within their expiry date and suitable for use. All the medicines we checked within these areas were within their expiry dates. We looked at the emergency medicines at the practice and found the majority to be in date and fit for use. However; there was not a clear system in place for monitoring the expiry dates of medicines in GP bags and we identified some drugs that had passed their expiry date in one bag.

We saw records of practice meetings that showed the practice had taken account of NICE guidelines. For example the use of statins for patients with a cardiovascular disease (CVD) risk of more than 10%.

Vaccines were administered by the practice nursing team using protocols that had been produced in line with legal requirements and national guidance. We saw evidence that the practice nursing team had received appropriate training to administer vaccines.

The practice staff followed a repeat prescribing protocol which was in line with national guidance. Staff described the system they used to follow up with patients prescriptions that had not been collected. There was a system and protocol in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example; patients who were prescribed Amber Drugs. These are drugs that should be initiated by a specialist, and which require significant monitoring on an on-going basis.

All prescriptions were reviewed and signed by the GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw that the practice had a prescription security protocol.

Any medicines alerts that were received were reviewed by the practice manager and then disseminated to all clinical staff and discussed in practice meetings.

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 told us the practice was always clean.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy. All clinical staff had completed training in infection control. We saw infection control audits for the past two years and any improvements identified for action were mostly completed in a timely way.

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 (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Patients told us they saw PPE being used by staff. Sharps bins were available, and in most cases appropriately stored. Bins with lids and foot pedals for the disposal of general and clinical waste were in place. Special kits to be used in the event of a spillage of blood or body fluids were available and stored appropriately. A needle stick injury policy was in place. Hand wash and safe hand washing guidance was displayed in treatment rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We looked in the clinical areas and found the majority of them to be satisfactory. However; we did see unsuitable flooring in a room used by a health care assistant. An action plan was in place to replace the carpet that was dated March 2014 but the practice did not have a date for when the carpet would be replaced.

The practice had a policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that 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 thermometers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that was regularly reviewed.

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 minutes of staff meetings where staffing was regularly discussed; ensuring there was enough staff on duty at all times. We saw evidence that the practice had taken action to recruit a nurse practitioner in response to feedback in relation to staffing levels. There were arrangements in place for requesting annual leave to ensure all roles were adequately covered.

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.

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 the environment, medicines management, staffing and 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. Arrangements for monitoring the suitability and safety of the building were carried out by an external contractor. The records showed appropriate checks were carried out.

The practice did not keep a central log of identified risks. Identified risks were recorded in area specific individual risk assessments, for example infection control. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the risk to staffing levels was discussed and actions put in place to address the issues. We were also told that as a result of some patient notes being misplaced when visiting patients outside of the practice, the new nurse practitioner would start working with electronic records when outside of the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage most emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines for use within the practice were within their expiry date and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. 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. However, the practice did not have arrangements in place to ensure relevant staff could access these emergency numbers due to the continuity plan being stored within the practice.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. There were designated staff at the practice to co-ordinate an evacuation of the building in the event of an emergency and information was displayed within patient waiting areas.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance accessing supporting information from the NICE and from local commissioners. Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed. We saw minutes of practice meetings where new guidance was discussed, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Staff we spoke with and the evidence we reviewed demonstrated that there were appropriate clinical and nursing leads in specialist clinical areas such as diabetes, heart disease and asthma and the practice nursing staff supported this work which allowed the practice to focus on specific conditions. The practice had management plans in place to support those patients with long term conditions such as asthma, diabetes and COPD.

The practice had effective systems in place for monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example annual health checks and cervical smears. There were also systems in place for reviewing patients who had recently been discharged from hospital and who had changes in their medication.

Management, monitoring and improving outcomes for people

Staff at the practice had key roles in monitoring and improving outcomes for patients. These roles included recalling patients for clinical reviews, monitoring performance of the practice against areas such as the quality and outcomes framework (QOF), CCG initiatives and medicines management.

The practice showed us three examples of clinical audits that had been undertaken in the last 12 months. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

For example, the chaperone audit that was completed resulted in improved recording in patients' notes about chaperones being offered and used. The COPD points audit showed improvement in the way patients with COPD were managed. Other examples of audits included the use of certain medicines by patients using them for more than two years.

The GPs told us clinical audits were often linked to medicines management information, safety alerts, and information within the practice or as a result of information from the QOF. QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of Diclofenac following a medicine alert. Following the audit, the GPs carried out medication reviews for patients who were prescribed this medicine and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had achieved a QOF score of 100% in all areas.

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.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question.

When available, the practice also participated in local benchmarking. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. We saw an example where the practice had compared its performance of referrals against other practices in the CCG area.

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending essential courses such as annual basic life support. We noted a good skill mix among the staff group with staff having a range of qualifications. For example some GPs had a Diploma of the Royal College of Obstetricians and Gynaecologists and Diploma in Immediate Medical Care. Nurses had Diplomas in Nursing Studies, BA (Hons) in Nursing Studies and Diplomas in COPD, diabetes and Asthma. Non-clinical staff had a range of qualifications such as BA (Hons) in Business Management, LLB (Hons) and NVQs. 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. A Responsible Officer from NHS England makes a revalidation recommendation to the General Medical Council (GMC) (normally once every 5 years) and the GMC then makes the decision whether or not to revalidate the GP and continue to practice and remain on the performers list).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one member of staff was completing a Diploma in Heart Failure. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to two GP trainers throughout the day for support. The practice had been awarded the Team Excellence Award 2014 from Hull York Medical School; an award which the medical students nominated the practice for.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, records showed staff had completed training in areas such as cervical cytology and the administration of vaccinations. We were told by staff that they were not expected to complete roles outside of those tasks they had been assessed or trained as being competent to do so. Those with extended roles, for example running clinics for patients with long-term conditions such as asthma and diabetes were also able to demonstrate that they had completed training to enable them to fulfil these roles.

The practice utilised local apprentice schemes for employing some staff. We saw evidence to show apprentices had been supported to gain qualifications and develop into more advanced roles; for example managerial roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. They 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 communications with other care providers on the day they were received. 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. Minutes of meetings showed changes to practice arrangements had been discussed to ensure information was acted on when staff worked part time.

The practice was commissioned for the new 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).

The practice held informal meetings with staff from other services. We spoke with the health visitor and an Addictive Behaviour Service (ABS) worker; both provided services at the practice. They told us they had established working arrangements with the practice and met regularly to discuss any issues. They told us the practice staff were accessible and there were good lines of communications. The practice did not hold any formal documented multi-disciplinary meetings and the practice acknowledged the need to introduce such meetings and brought this to our attention at the start of the inspection.

Information sharing

There was effective communication and information sharing and decision making about a patient's care across all of the services involved both internal and external to the practice. 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. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The

Are services effective?

(for example, treatment is effective)

Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice.

Patients with learning disabilities 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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions which practice staff followed.

Health promotion and prevention

The practice had a range of information available for patients displayed in the patient waiting area and on the practice website relating to health prevention and promotion. This included information on sexual health, children's health, long term conditions such as asthma, information for people who suffer from mental ill health and learning disabilities, and general health promotions that included smoking cessation, bowel cancer and alcohol awareness.

New patients registering with the practice completed a health questionnaire and were given a new patient medical

appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and was offered an annual physical health check. We saw evidence that the practice had systems in place to recall patients to the practice or to share health information with them, for a range of areas; for example cervical screening refusal, health checks for carers, thyroid, coil checks and rheumatoid arthritis review.

The practice was linked with Scarborough University Campus. The practice staff attended Fresher's week at the University where they offered on campus health assessments for students who wished to register. Students were provided health information packs. Health and well-being events also took place at the University throughout the year and the practice worked in conjunction with the University Counselling Service.

The practice's performance for cervical smear uptake was 80.26% compared to the national average of 81.83%. The practice had a system in place to remind patients who did not attend for cervical smears. The practice also had other systems in place for recalling and reminding patients of other health checks.

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 for the percentage of children who were eligible for immunisations at aged 12 months that receive immunisations was slightly below the Clinical Commissioning Group (CCG) average and the percentage of Children aged 24 months and 5 years who are eligible for immunisations that receive immunisations and at 24 months and aged 5 years was slightly above the CCG. We saw evidence that the practice was pro-active in following up patients who did not attend for their immunisations; working in conjunction with health visitors.

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. 321 surveys were issued and 119 completed; which equates to a 37% completion rate. Of the respondents the evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 92% described their overall experience of the surgery as good; which is above the weighted CCG average. The practice was below the weighted CCG average for its satisfaction scores on consultations with doctors and nurses with 87% saying the GP and 83% saying the nurse was good at listening to them and 89% saying the GP and 86% saying the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. The majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff listened, were helpful, supportive and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with three patients on the day of our inspection and two members of the PPG. 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 that all consultations and treatments were carried out in the privacy of a consulting room. However two patients told us not all staff knocked before entering the room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. A separate consultation room was available for reception staff to use if needed. All of the reception desk was shielded by glass partitions and there was also a self-check in area so patients could check in without any identifiable information being seen or overheard.

Care planning and involvement in decisions about care and treatment

The patient survey 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. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were slightly below the weighted CCG average. The practice's own satisfaction survey showed no concerns were raised by patients about involvement in decisions about their care and treatment.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Translation service information was also available on the practice website. The practice told us they assessed the most suitable way of communicating with patients. They provided us with an example where the practice had communicated with a family via video link who were deaf and whose first language was not English.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us that staff responded compassionately when they needed help and provided support when required. We spoke with two healthcare workers who were associated with the practice. They told us the practice overall was caring towards its patients.

The practice provided information and support to patients who were bereaved and for carers. The practice provided literature and signposting to support groups and organisations within the practice and on the practice

Are services caring?

website. The practice maintained a list of carers and they were offered an annual health check. The practice had identified those patients that were veterans to ensure they were offered priority treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The practice recognised the need for additional clinical staff as the patient list size was growing and had appointed a nurse practitioner who was due to commence in December 2014. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. An example of this is the arrangements the practice had in place for patients with mental ill health. Belgrave Surgery had double the national prevalence of patients with mental health problems. Patients were offered mental health checks and weekly arrangements were in place for patients to access an addictive behaviour service worker and or a primary care mental health worker at the practice if required. The practice also accessed the University Counselling Service.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice participated in providing data returns to the CCG and used this information to monitor and improve their performance. For example accident and emergency unplanned admissions. The practice had also implemented suggestions for improvements and made changes to the way it delivered; for example in response to significant events and from feedback from the patient participation group (PPG).

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. Staff told us how they assessed the most appropriate way to communicate with patients.

The practice did not provide specific equality and diversity training for staff; although staff were clear that all staff were treated equally. The practice's Patient Charter stated; 'We will offer you courtesy and respect at all times whatever your gender, race, religious beliefs, sexual orientation or nature of your health problems.'

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the clinical staff demonstrated that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

The practice was situated across a number of floors with lift access available. There was sufficient space in the practice to accommodate patients with wheelchairs and prams and to allow easy access to treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The seats in the waiting area were all of one height and size. There was no variation for diversity in physical health. Audio loop was available for patients who were hard of hearing.

Access to the service

The practice offered extended appointment availability from 8am to 8pm on weekdays in partnership with Falsgrave Surgery. They also offered telephone consultations. This is particularly useful for patients with working commitments.

Information was available to patients about appointments on the practice website. This included how to book appointments via the surgery and on-line. There was also information about arranging urgent appointments, home visits and information about what a patient needed to do to ensure they 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. Patients were sent reminders about appointments by text message.

The national GP survey results published in July 2014 showed that 94% of respondents found it easy to get through to the surgery by phone. The practice had installed an additional phone line to improve their call response times. 91% of patients said they found the receptionists helpful. 96% said the last appointment they got was convenient. However; 64% patients said they usually got to see or speak to their preferred GP. We saw evidence from the practice patient survey in 2013 – 2014 that highlighted appointments with specific GPs as an issue. We saw the PPG had agreed the practice would increase GP sessions by four per week to allow patients greater choice when booking appointments in advance.

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes to those patients who needed one. Patients could also access other services at the practice, for example Podiatry Service.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, we spoke with one patient on the day of our inspection that had been given an appointment to see a GP within 40 minutes of calling for an appointment.

Listening and learning from concerns and complaints

Information on how to complain was available in the practice information booklet. 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.

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 looked at seven complaints received since March 2014 and found these were handled satisfactorily and had been dealt with in a timely and person centred way.

Patients knew how to raise concerns or make a complaint. Information on how to complain was displayed in the reception area and in the practice guide. We looked at seven complaints received in the last twelve months and found they had been satisfactorily handled and dealt with in a timely manner. Each person was contacted by the practice to try and reach a satisfactory outcome for the complainant. We also saw that complaints were referred for discussion at management meetings where learning points were discussed.

There was a complaints/suggestions box in the waiting area which staff checked regularly.

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. We found details of the practice's core values as part of the practice's patient charter. The practice core values were:

Patients: Putting patients at the heart of everything we do

Quality: Providing the highest standard of care and treatment. We encapsulate high quality Health Promotion, providing preventative advice and supportive care to enable every patient to achieve their own optimum levels of self-care, health & wellbeing.

Compassionate & Caring: Being compassionate about enhancing caring for our patients.

Well trained staff: We strive to maintain an innovative and evidence-based approach to primary care practice, within our HYMS award winning educational context, by supporting and incorporating the thoughts, ideas, knowledge and learning of all who work within our organisation.

All the staff we spoke with were clear of the practice's core values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in paper format. We looked at 10 of these policies and all had been reviewed and were up to date; although there was no evidence to show that staff had read them.

There was a clear leadership structure with named members of staff in lead roles. For example, there was an information governance, safeguarding and infection control lead. There were lead nurses for specific long term conditions. All staff were clear about their own roles and responsibilities and those of their colleagues. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the QOF to measure its performance. The QOF data for this practice was at 100% which showed it was

performing above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had arrangements in place for completing clinical audits and monitoring against the QOF, LES (Local Enhanced Services) and DES (Direct Enhanced Services) which were used to monitor quality and performance of the practice. There were also mechanisms in place for discussing and addressing areas for improvement; for example governance meetings.

The practice had arrangements for identifying, recording and managing risks. The practice did not maintain a central risk register but carried out a range of individual risk assessments. These shows risks were identified and action plans produced and implemented. We saw risks were regularly discussed at team meetings. For example we saw risks to staffing levels on particular days had been discussed and actions put in place to address this. The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. The practice also held a range of other meetings; such as administrative meetings. The practice recognised the need to introduce clinical meetings to ensure all clinical staff attended a meeting rather than GP and nurse leads, as well as introducing more formal multi-disciplinary meetings.

Leadership, openness and transparency

The practice had a clear leadership structure in place. Staff had been allocated lead roles; for example the practice manager led on information governance, a GP on safeguarding and a nurse on infection control. All staff were clear about their own and their teams roles and responsibilities.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example sickness management, study and training and grievance, which were in place to support staff. A staff handbook was made available to staff.

Staff told us the meetings and information sharing at the practice helped them keep up to date with new developments and any issues. It also gave them an opportunity to make suggestions and provide feedback to the team. Staff told us there was an open culture at the

Are services well-led?

Good 

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

practice. They told us they were encouraged to have a voice. We saw evidence that regular team meetings were held and staff had raised issues and they had been discussed and considered.

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

The practice had gathered feedback from patients through patient surveys, comment cards, significant events and complaints received. We saw the practice had taken action as a result of patient and public feedback.

The practice had an active patient participation group (PPG). The last patient survey was considered in conjunction with the PPG and an action plan put in place. The results and agreed actions from these surveys are available on the practice website.

The practice did not formally gather feedback via a survey but staff were encouraged to provide feedback in other ways; for example through staff meetings, appraisal and discussions. 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 in the practice to improve outcomes for both staff and patients. One member of staff told us they had never felt so well supported.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to develop through training and mentoring. They said the practice was generous with the time allowed for training and personal development. Staff completed mandatory training such as infection control and safeguarding; and in addition could also access other specific training to support them in their current role, as part of their personal development but also if identified as a need for the practice. Staff told us the practice encouraged learning and improvement through meetings and through staff appraisals. We saw staff received regular appraisals.

The practice was a GP training practice. It had two GP trainers and was involved in the vocational training of fully qualified doctors who wished to enter general practice. The practice had been awarded the Team Excellence Award 2014 from Hull York Medical School; an award which is nominated by medical students.