Derwent Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Derwent Practice on 13 November 2014. Derwent Practice provides primary medical care services to patients living in and around the area of Malton, North Yorkshire.

We rated the practice overall as good.

Our key findings were as follows:

The leadership, governance and culture were used to drive and improve the delivery of quality, person-centred care.

Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.

Patients said, and our observations confirmed, they were treated with kindness and respect.

The practice was visibly clean and tidy.

The practice learned from incidents and took action to prevent a recurrence.

The practice safely and effectively provided services for all patient groups. The staff were caring and ensured all treatments being provided followed best practice guidance. The practice was well-led and responsive to patients' needs.

Systems were in place for the dispensing of and management of medicines.

The provider should:

Ensure staff have received training in adult safeguarding.

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

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Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and 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 was enough staff to keep people safe. Staff were aware of the process regarding safeguarding however some required training in respect of vulnerable adults.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence, (NICE) guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles and further training needs have been identified and planned. Multidisciplinary working was evidenced.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning

Summary of findings

Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision for improving the service and promoting good patient outcomes. An effective governance framework was in place. 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 regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-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 and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the

Summary of findings

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice held a register which identified which patients fell into this group, and used this information to ensure they received an annual healthcare review and access to other relevant checks and tests.

Staff worked with multi-disciplinary teams to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise and report signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing and how to contact relevant agencies, in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. The practice could access community mental health services. The staff were familiar with the support service available for patients experiencing poor mental health in the local area and were able to sign post patients to these services.

Summary of findings

What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received five completed CQC comment cards and spoke with 14 patients who were attending the practice on the day of inspection. We spoke with people from different age groups, including parents and children, patients with different physical conditions and long-term care needs. The patients we spoke with were extremely complimentary about the staff and clinicians, as were all of the cqc comments cards. Patients told us they found the staff to be very helpful and felt they were treated with respect.

Findings from the 2014 Patient Survey indicated a high level of satisfaction with the care and treatment provided by the practice;

68% of respondents could see a GP urgently on the same day

71% of respondents could easily book an appointment ahead

91% of respondents said the GP gave them enough time

89% of respondents were treated with care and concern by the nurse

93% of respondents had confidence and trust in the nurse they saw

91% of respondents said the nurse gave them enough time

Areas for improvement

Action the service SHOULD take to improve
Staff had not received training in adult safeguarding.

Derwent Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a Practice Manager and a second CQC inspector.

Background to Derwent Practice

Derwent Practice, Norton Rd, Norton, Malton, YO17 9RF is situated in Malton and is near bus and railway stations. The registered patient list size of the practice is 19,600. The practice has seven GP partners and six salaried GP's, a mix of male and female. It is a training practice and a dispensing practice. There are six practice nurses, two health care assistants and three phlebtomists. The practice has a practice manager, an assistant practice manager and a team of receptionists and administration staff.

A range of services and clinics are provided including, clinics for patients with heart disease, hypertension and asthma.

The practice has a Personal Medical Services 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. When the practice is closed patients access out-of-hours care via the 111 service.

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.

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

How we carried out this inspection

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

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

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

- Older people

Detailed findings

- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 13 November 2014.

During our visit we spoke with a range of staff including two GP partners, the practice manager, nurse manager, two practice nurses, a healthcare assistant and reception staff.

We spoke with 14 patients who used the service and reviewed five CQC comment cards where patients were able to share their views and experiences of the service. We observed how people were being cared for and talked with carers and/or family members.

Good

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013 the practice did not declare any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. We had not been informed of any safeguarding or whistle-blowing concerns relating to patients who used the practice. The local CCG told us they had no concerns about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda which occurred monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Once incident forms were completed they were discussed with the practice manager and risk management was regularly reviewed within the practice. We reviewed nine significant event analysis (SEAs) undertaken in 2013/14 and saw records were completed in a comprehensive and timely manner. For example the process of prescribing for one patient had been re visited 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.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding for children. We asked members of medical, nursing and administrative staff about their most recent training. Whilst staff knew how to recognise signs of abuse in older people, vulnerable adults and children they required training in adult safeguarding. At the time of the inspection the practice manager was trying to source this training. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children and they had been trained. All GP's in the practice had completed level 3 in safeguarding. All staff we spoke to were aware who the lead was 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 so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

For patients with learning disabilities their annual reviews were undertaken by a nurse practitioner. The nurse had an extended appointment time available and was able to refer to the GP when needed.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient, including scanned copies of

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

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff and staff knew what action to take in the event of a potential power failure and refrigerator malfunction.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a 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.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk. We observed this process was working in practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

The practice had established a service for people to pick up their dispensed prescriptions at the practice and had systems in place to monitor how these medicines were collected.

Cleanliness & Infection Control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and thereafter, annual updates. We saw infection control audits for the last three years and that improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan

and implement control of infection measures. For example, personal protective equipment, including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. Sharps bins were available, and 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 There was also a policy for how staff would deal with a needle stick injury.

Hand washing signage was displayed in staff and patient toilets. Hand washing sinks with soap, alcohol gel and paper towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had sufficient 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 and we saw evidence of calibration of relevant equipment; for example patient weighing scales. Fire equipment checks were carried out regularly and a fire risk assessment had been completed. Current gas safety and electrical installation certificates were in place.

Staffing & Recruitment

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

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

Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy, which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe.

Where risks had been identified they had been documented, and actions recorded to reduce and manage the risk. Staff were able to identify and respond to changing risks to patients, such as deterioration in their health and well-being, or a medical emergency. For example, emergency processes were in place to help reduce hospital admissions for patients with long-term conditions. This included providing a RESCUE pack for patients with breathing difficulties to help them better manage their condition. (RESCUE packs contain medicines for patients with breathing difficulties to use at home if their condition deteriorated as part of their self-management strategy).

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available, including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke to knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in an area that only practice staff could access. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan specifying the action to be taken in relation to a range of potential

Good

Are services safe?

emergencies that could impact on the daily operation of the practice. Risks identified included incapacity of the GP partners and the loss of the computer and telephone systems. The document also contained emergency contact details for staff to refer to. For example, contact details of the company responsible for servicing the building.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. 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. 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 chronic obstructive pulmonary disease (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.

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to, and for children and young people Gillick assessments were completed. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

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. 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 Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of aspirin in atrial fibrillation (a heart condition). 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 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 upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

Good

Are services effective?

(for example, treatment is effective)

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors. For example some had additional diplomas in sexual and reproductive medicine, orthopaedic medicine and palliative care. Nurses had diplomas in Diabetes, Asthma and COPD. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments when they saw patients and had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example running clinics for patients with long term conditions such as asthma and diabetes, were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, x ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings every month to discuss the needs of complex patents e.g. those with end of life care needs or children on the at risk register and decisions about care planning were documented.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice no longer used the Choose and Book system for making referrals. The GPs preferred to consult directly with the patient about their choices of hospitals and make direct referrals themselves.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospitals, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) 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.

Good

Are services effective?

(for example, treatment is effective)

Health Promotion & 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 promotion 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 they were 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 offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013 National GP Patient Survey, and a survey of patients undertaken in January 2014 by the practice's PPG. The evidence from these sources showed that the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received.

Data from the Patient Survey showed the practice was rated above the regional CCG average in most of the areas covered. For example, of the patients who responded: 91% said the last GP they saw, or spoke to, was good at giving them enough time; 90% said the last nurse they saw, or spoke to, was good at listening to them; 89% and 90% of patients said both the last GP and nurse they saw, or spoke to, was good at treating them with care and concern respectively.

We received five completed CQC comment cards. The feedback was positive and no concerns were raised. We also spoke with 14 patients on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical health care needs and those who had various levels of contact with the practice. All these patients were complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They all felt the doctors and nurses were competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so 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.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

We saw that staff spoke with patients in a quiet and confidential manner. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained patients could also ask to speak with staff in private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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. The results from the survey showed that 98% of patients said they were sufficiently involved in making decisions about their care.

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.

The practice had an 'access to records' consent policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information about the policy was available for patients on the practice website and in leaflets.

Good

Are services caring?

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 area informing patients this service was available.

The practice also had an emergency multilingual phrasebook available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

We saw that the staff had detailed knowledge of the patients they served and kept registers in respect of who had learning disabilities; carer responsibilities; mental health needs and complex health conditions. Staff provided additional support mechanisms for these people such as home visits; organising early appointments for nervous patients and arranging appointments around carer's availability.

We saw evidence that the practice worked jointly with the health visitor and school nurse to address the needs of children and families in the area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. Care plans were in place for patients who had frequent admissions to hospital, to assess and manage their care in a way that reduced the need for them to go into hospital.

The NHS Local Area Team (LAT) 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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, the availability of the INR (international normalised ratio) monitoring service. INR is a measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants such as warfarin, on the clotting system.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. 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, by a named GP and to those patients who needed one.

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards and they were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff listened, were helpful, supportive and caring.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services, for example, those patients with a learning disability, patients with long term conditions and carers. The practice was able to identify different patient groups and respond to their needs. The practice actively promoted services available to people in the local community, for example the walk in flu clinics.

The premises at the surgery had been adapted to meet the needs of people with disabilities to access the service. There was sufficient space in the practice to accommodate patients with wheelchairs and prams and to allow easy access to treatment and consulting rooms. Accessible toilet facilities were available for all patients. An audio loop was available for patients who were hard of hearing.

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.

Access to the service

Appointments were available from 8am to 8pm pm on Mondays, 8am to 7pm Tuesday to Friday and 8am to 12pm on Saturday. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring, depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor 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.

The practice's extended opening hours on Monday and Saturday was particularly useful to patients with work commitments. This was confirmed by a patient spoken with during the inspection.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. Posters were displayed in the waiting area and information was also in the practices' summary leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at nine complaints received in the last twelve months, seven had been handled satisfactorily, dealt with in a timely manner and to the satisfaction of the patient concerned and two were still on-going.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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. In the patient information it stated 'The team work together to provide the highest quality healthcare at the same time meeting ever changing needs of its patients and the community'. The practice also set out 'expectations' the practice aims for, for example a caring attitude to patients' problems and a willingness to work with the patient to resolve their problems.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw and were told that staff regularly came together at a range of formal meetings to discuss practice business, training, future developments and patients ongoing care.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at ten of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All ten policies and procedures we looked at had been reviewed annually and were up to date.

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 used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with 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 completed a number of clinical audits. For example, it had carried out an audit of its prescribing practice in relation to the use of a particular medicine which had been restricted to patients with a specific condition and for private prescriptions. A change was made following the expiry of the drug's patent and the medication became more widely available under the NHS. All patients were identified and prescriptions changed to NHS prescriptions.

The practice had also carried out an audit looking at preventing osteoporosis in patients with coeliac disease. A number of patients were identified as to be at risk of osteoporosis and fragility fracture. The practice looked at how many patients had received a DEXA (an enhanced form of x ray technology to scan the bone density) to assess their bone density. GP's were tasked to recommend a DEXA to their patients who had not received this before. The audit was repeated in January 2014 and there had been an uptake in the number of patients having a DEXA. A further audit was to be carried out.

The practice had suitable arrangements in place for identifying, recording and managing risks. For example, an up-to-date fire safety risk assessment was in place, and there were risk assessments to minimise the risks associated with the use of IT equipment.

Leadership, openness and transparency

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

We saw from minutes that meetings were held regularly, at least monthly. Some of the meetings were held twice, as due to the number of people working in the practice there were too many for everyone to attend one meeting. . There were no clinical meetings for GP's and nurses together; information from meetings where nurses did not attend was cascaded via the practice manager. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, management of sickness, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, this included sections on equality, and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through patient surveys, complaints and compliments received, which they shared with staff. We looked at the results of the annual patient survey and saw the overall patient satisfaction was high with patients saying they would recommend the practice to a friend. Some patients were dissatisfied with the availability of appointments and getting through on the telephone. The practice was aware of the problems with the telephone system and at the time of the inspection management was in the process of choosing another system to be installed. The practice had also introduced a triage system with a practice nurse for urgent appointments to signpost patients to either a Doctor or Nurse. At the time of the inspection it was too soon to review if this change had led to any improvements.

The patient participation group (PPG) were very active and had steadily increased in size. The group was well established and had representatives from various population groups. The PPG met every quarter and representatives from the practice always attended to support the group. There was usually a speaker at the meetings, for example a member of staff from the development team at Malton and Selby Hospital had attended. They had given an overview of plans for community care with collaborative working between health and social services.

The PPG had discussed the patient surveys and identified further areas such as cleanliness in the practice, to be added to the next survey.

The practice had gathered feedback from staff through staff meetings, appraisals 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.

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place where training was discussed. Staff told us that the practice was very supportive of training and staff could access courses they required to fulfil their roles and responsibilities.

The practice is a GP training practice and teaches FY2 Doctors, Year 3 and Year 5 medical students. Several of the GPs are trainers and tutors. This meant the practice had an active role in the training of doctors specialising in general practice.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings, and minutes showed these events were discussed, with actions taken to reduce the risk of them happening again. Staff we spoke with referred to the open and honest culture within the practice and the leadership's desire to learn and improve outcomes for patients.