South Milford Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 14 July 2015 at South Milford Surgery as part of our comprehensive programme of inspection of primary medical services. We also visited their two branch surgeries in Micklefield and Thorpe Willoughby.

Overall the practice is rated as GOOD.

Specifically, we found the practice provided safe, well-led, effective, caring and responsive services. It was rated as good for all of the population groups.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- The practice was clean and hygienic

We saw several areas of outstanding practice including:

- The practice as part of SHIELD (The Selby Area Federation of GP Practices) had won an innovation fund, to develop social prescribing. This fund was used initially to support the local voluntary service to produce an up to date data base of available voluntary social care organisations. Patients were then referred to the most appropriate services.
- The practice provided minor injuries clinics to avoid unnecessary journeys to the nearest hospital. Information showed there were fewer A & E attendances, compared with other GP practices within the CCG.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GPs took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. There was evidence of good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. Safe staff recruitment practices were followed and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Care and treatment was being delivered in line with current published best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE), and the local clinical commissioning group (CCG).

Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development (CPD). There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients were respected and valued as individuals and were partners in their care. Feedback from patients was positive. Patients we spoke with and those who completed CQC comment cards were overwhelmingly complimentary about the practice. They said they were treated with dignity and respect and they were involved in care and treatment decisions.

The GPs provided a compassionate service for their population. They said they would rather see patients themselves and treat any illnesses or minor injuries than send them to hospital.

Summary of findings

Accessible information was provided to help patients understand the care available to them. We found there was a patient-centred culture and staff treated patients with kindness and compassion. Staff we spoke with were aware of the importance of maintaining patient confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Patients said they found it easy to make an appointment with a GP and that there was some continuity of care, with urgent appointments available the same day. We were told by the management team of their intention to make changes to the appointment system to improve accessibility and continuity of care.

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. Learning from complaints with staff and other stakeholders was reviewed and acted upon.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had an active virtual patient participation group (PPG).

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 patients.

The practice offered proactive, personalised care to meet their needs. Nationally reported Quality Outcomes Framework (QOF) data showed the practice had good outcomes for conditions commonly found in this age group. The practice was responsive to their needs, understanding the impact of the rural environment for their patients. They provided annual health checks for elderly patients and where suitable, home visits. There was a strong commitment to providing co-ordinated, responsive and compassionate care for patients nearing the end of their lives. Individualised care plans were in place for those patients who were being treated by the multi-disciplinary team.

The clinicians were proactive in reducing risks associated with polypharmacy for older people. For example, patients prescribed multiple different medicines had been frequently reviewed and changes made to reduce these, where necessary.

Information systems enabled the practice to appropriately share important clinical and social information about patients with complex needs. This facilitated continuity of care for those patients. Hospital discharges were followed up.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nursing staff had lead roles in chronic disease management and had dedicated appointments to review patients with diabetes, asthma and/or chronic respiratory disease. Patients at risk of hospital admission were identified as a priority. All these patients had a named GP and a structured annual review to check that 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. The practice held multidisciplinary meetings every month to review the needs of all patients with complex long term conditions.

Appointments were structured to avoid multiple visits to the practice and home visits were available when needed.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged

screening for certain conditions to be carried out at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by some patients we spoke with as it avoided them having to travel to the eye clinic based at the main hospital.

The practice had links with external health care professionals to provide advice and guidance as required.

Health education around diet and lifestyle was promoted by the GPs and nursing staff. The practice took an early intervention approach and helped identify and signpost patients to external support. This included assistance with smoking cessation and contact details for the health worker running this service was given to patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The waiting room had toys for children to play with whilst waiting for their appointments.

Emergency processes were in place for acutely ill children, young people and pregnant women with acute complications.

The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance.

Parents with children attending the practice confirmed that they were always present during consultations. Staff understood Gillick principles with regard to assessing whether a young person was able to understand and therefore consent to treatment. Parents told us that all of the staff engaged well with their children and they found it a positive experience when attending the practice for appointments.

The practice provided minor injuries clinics to avoid unnecessary journeys to the nearest hospital. Information showed there were fewer A & E attendances from this age group, compared to other GP practices.

Summary of findings

Working age people (including those recently retired and students)

Good

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

The needs of this group 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 able to provide the service for working patients so they would be able to book appointments and repeat prescriptions on-line. The practice website offered information about the full range of health promotion and screening available for this group. The practice had extended opening every Monday evening and Tuesday mornings from 7am, for working patients. Appointments were available for patients to see a GP, or the Advanced Nurse practitioner. Patients would be able to request repeat prescriptions on-line, via an automated telephone system or in person at the practice. Repeat prescriptions were given for up to six months, where clinically appropriate.

Overseas travel advice including up-to-date vaccinations was available from the nursing staff within the practice, with additional input from the GPs as required.

Opportunistic health checks were being carried out with patients when they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders for medication reviews.

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. We were told these patients were never turned away. Links had been made with local health and social care teams and joint patient review meetings took place to discuss the most vulnerable patients. The practice held a register of patients with learning disabilities and offered them annual health checks and longer appointment times. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for patients who experience poor mental health (including patients with dementia). Practice staff were aware of their patients with poor mental health and offered support

to meet their needs. All patients experiencing poor mental health received an annual physical health check. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.

Arrangements were in place for dispensing staff to flag up any concerns regarding over or under ordering of medicines. Staff worked to a Standard Operating Procedure for patients on certain medicines. Patients who experienced poor mental health were supported appropriately. This included a counselling service as clinics were held at the surgery each week.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection and reviewed 18 completed CQC comments cards. The feedback we received was mainly positive. All 18 cards had positive remarks about care, attention, and support being excellent. Staff were described as attentive, friendly and helpful. We were told patients received an excellent service from reception staff through to the doctors. However eight of the patients who had completed the CQC comments cards had some negative comments to add. These included the high turnover of GPs, problems with the telephone system and sometimes the reception staff could be less attentive. These comments were not supported by the patients we spoke with on the day of our inspection.

The GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published on 8 January 2015 showed the practice scored above 90% in four out of the 14 questions asked. They scored between 70-89% in 11 of the questions and in two of the questions they scored between 63% and 46%

46% of respondents said they got to speak with a preferred GP compared to the CCG average of 64%.

96% had confidence in the last GP they spoke with compared to the CCG average of 97%.

95% had confidence in the last nurse they spoke with compared to the CCG average of 98%.

87% said the last GP they saw was good at treating them with care and attention compared to the CCG average of 88%.

There were 265 survey forms distributed for South Milford Surgery and 124 forms were returned. This is a response rate of 46.8%. This number equates to less than 1.5% of the practice population.

Outstanding practice

- The practice as part of SHIELD (The Selby Area Federation of GP Practices) had won an innovation fund, to develop social prescribing. This fund was used initially to support the local voluntary service to produce an up to date data base of available voluntary social care organisations. Patients were then referred to the most appropriate services.
- The practice provided minor injuries clinics to avoid unnecessary journeys to the nearest hospital. Information showed there were fewer A & E attendances, compared with other GP practices within the CCG.

South Milford Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP Specialist Advisor (SpA), a Practice Manager SpA and another CQC inspector.

Background to South Milford Surgery

South Milford Surgery is located in a purpose built building on the High Street in South Milford. There are two branch surgeries, one in Micklefield and one in Thorpe Willoughby. All are dispensing surgeries. The practice provides General Medical Services (GMS) under a contract with NHS England, North Yorkshire and Humber Area Team, to the practice population of 9,753 patients.

There is a mix of female and male staff at the practice. Staffing at the practice is made up of three GP partners (two female and one male) and three salaried GPs (two male and one female). The practice manager is also a managing partner in the practice. There is one female advanced nurse practitioner, two female practice nurses, two female health care assistants and two female phlebotomists. There are dispensing staff and a range of administration and secretarial staff.

Appointments are available Monday to Friday from 8.00am to 11am and 15.20 to 6.00pm. Extended hours are available on Monday evenings until 19.30 and from 7.00am on Tuesday mornings. The practice closes between 1.00pm and 2.00pm each day. Micklefield surgery is open Monday to Friday from 08.30 -11.45 and is open Monday and Wednesday afternoons from 15.20- 18.00. Thorpe Willoughby surgery is open Monday to Friday from 08.30 – 11.45.

When closed the OOH provider is North Yorkshire Doctors; information about this service is provided on the practice's website and on the surgery telephone answer machine.

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

Before visiting, we reviewed a range of information we held about the practice and asked other organisations such as Health Watch, to share what they knew. We carried out an announced visit on 14 July 2015. During our visit we spoke with 10 members of staff, these included GPs, the practice manager, dispensing staff, nurse practitioner, secretaries and reception staff at all three surgery sites. We spoke with patients who used the service and two members of the

Detailed findings

virtual Patient Participation Group (PPG). We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources. These included the Quality and Outcomes Framework (QOF), patient survey results, the Patient Participation Group (PPG), clinical audits, professional development, and education and training.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the clinical, management meetings and with relevant staff. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the clinical practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at their meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked incidents and saw records were completed in a comprehensive and timely manner. The actions and investigations were detailed and protocols were revisited, to assure they were appropriate. 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 to practice staff by email, on-line tasks or in meetings. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They confirmed alerts were discussed in meetings to ensure staff were aware of any relevant to their practice and where they needed to take action.

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 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 the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and felt confident they would be supported 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; for example children subject to child protection plans. This was to ensure risks to children and young patients, who were looked after or on child protection plans, were known and reviewed.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. All had a clear Disclosure and Barring Service check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Good

Are services safe?

Medicines management

We checked procedures for medicines management and these were available for each process undertaken by staff in the dispensary. We found staff signed and dated the procedures to confirm that they had read them. We checked medicines stored in the dispensaries, treatment rooms and medicine refrigerators. There was a clear policy for ensuring medicines were kept at the required temperature. We found that storage was safe and secure, and medicines were within their expiry dates. Medicines were stored at the correct temperature so that they were fit for use. The temperature of the medicines refrigerators and the dispensaries were monitored daily. There was a system to check the emergency medicines to ensure the correct stock level and expiry dates.

Patients were able to order their repeat prescriptions in person, in writing using the medicines list on the prescription counterfoil, or on-line. There were strict processes in place so staff could only issue repeat prescriptions and dispense medicines, which were up-to-date on the repeat prescription record. Only GPs and the Nurse Practitioner were able to make changes to repeat prescription records for example, after discharge from hospital or following medication review. Dispensary staff were able to make changes to repeat prescription records for stoma products, only in line with dispensary procedures. Reception staff issued prescriptions for patients to take to their local pharmacy, and dispensary staff issued prescriptions and dispensed medicines for those eligible for 'doctor dispensing'. Staff explained how they made checks for compliance such as by checking under-ordering or over-ordering of medicines, and how these concerns were raised with GPs.

The procedure for ensuring prescriptions were signed by the GP before patients received their dispensed medicines was discussed. The practice had a robust policy and Standard Operating Procedure in place to assure the safety of their patients.

We discussed the management of high risk medicines, such as the blood thinning medicine called warfarin, with the dispensing staff. They explained the audit processes in place to make sure patients attended for regular monitoring so that repeat prescriptions could be issued safely.

We checked the arrangements for storing blank prescriptions. These needed to be kept secure to prevent mishandling, diversion and misuse. We found that these were locked away. We discussed the arrangements for managing national alerts relating to medicines, for example when medicines had to be removed from use due to manufacturing quality issues. The dispensary staff explained how these alerts were processed and we saw a recent record of actions taken.

Medicines liable to misuse, called Controlled Drugs, were not dispensed from any of the surgeries.

Staff who dispensed medicines were appropriately trained and had the necessary experience to undertake the task safely. The practice manager told us that the practice was signed up to the Dispensing Services Quality Scheme (DSQS) this rewards practices for providing high quality services to patients of their dispensary.

The Advanced Nurse Practitioner and the practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

Cleanliness and infection control

We observed all of 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 surgeries 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 received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. We saw the action plan for updating the floors in some of the clinical rooms to meet current guidance.

An infection control policy and supporting procedures was available for staff to refer to, which enabled them to plan and implement measures to control infection. For example,

personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

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

Equipment

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

Staffing and recruitment

Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to staff commencing 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 setting out the standards it followed when recruiting clinical and non-clinical staff.

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

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. Two new recruits were joining the administration team. The practice was actively recruiting two salaried GPs and in the interim they were using more locums. We were told they tried to use locums known to the practice to support continuity of care for patients.

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 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. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw all risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were available and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned

Good

Are services safe?

sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment which included actions required for maintaining fire safety and we were told of safe evacuation training and practice.

Risks associated with service and staffing changes (both planned and unplanned) were included on the practice risk log.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, paediatrics, minor surgery, heart disease, sexual health and asthma. The nurse practitioner, the practice nurses, and the health care assistants supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for example, the management of respiratory disorders and diabetes, which were prevalent in the practice population. Our review of the clinical meeting minutes confirmed this happened.

We saw data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be contacted within a week by a named care co-ordinator. Where necessary an appointment to see their GP would be made according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers, which is within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

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

The practice showed us four clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We looked specifically at two completed audit cycles where the practice was able to demonstrate the changes since the initial audit. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. All the audits demonstrated improved outcomes for patients.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the identification of patients who were pre-diabetic. The monitoring of blood analysis determined whether or not they would be followed up. The audit was repeated the following year and there was found to be an increase in patients identified as fitting this category, which was in-line with national findings. The protocol was re–written. Standardised diet and lifestyle advice was given to these patients and they were followed up by the practice

Good

Are services effective?

(for example, treatment is effective)

nurses annually. The audit was due to be repeated shortly after this inspection where the findings were hoped to reflect the success of the changed protocol and show health improvement.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 85% of patients with high blood pressure had had a recording of 150/90 or less in the preceding nine months when reviewed, showing their condition was being managed effectively. The practice met all the minimum standards for QOF in diabetes, asthma, and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF or other national clinical targets.

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

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. They documented any changes necessary to each patient's records. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as external multi-disciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

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. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

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

All staff undertook annual appraisals where learning needs were identified and action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example the administration staff who wished to had recently undertaken chaperone training

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines, and cervical cytology. The Advanced Nurse Practitioner with an extended role saw patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease and they were 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 patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice outsourced

Good

Are services effective?

(for example, treatment is effective)

some administration tasks to an agent. This service had been risk assessed and the systems in place assured patient information was kept securely when transferred to and from the agent.

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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

We saw the policy for actioning hospital communications was working well. The practice undertook an annual audit of their follow-ups to ensure all were documented and that none were missed.

The practice had historically held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were valued by all team members and were well attended as appropriate by district nurses, social workers, and palliative care nurses. The discussions and decisions about care evaluation and planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. They were very clear they talked about patients and had begun to 'theme' the meetings to assure the most appropriate professionals attended.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, Choose and Book had now been replaced with Referral Support Service (RSS). Staff reported this system was easy to use and they felt it was better for patients.

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, and commented positively about the system's safety and ease of use. 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 where necessary action had been taken to address any shortcomings identified.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and they had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of Gillick competencies. (Used to help assess whether a child had the maturity to make decisions about their care and treatment and to understand the implications of these decisions).

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

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

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

Good

Are services effective?

(for example, treatment is effective)

The practice as part of SHIELD (The Selby Area Federation of GP Practices) had won an innovation fund, to develop social prescribing. This fund was used to support the local voluntary service to produce an up-to-date, data base of available voluntary social care organisations. Patients were then referred to the most appropriate services; this innovation was in its infancy. The database had been completed in May 2015.

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

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

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. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 82%, which was slightly higher than the CCG average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. There was also a named person responsible for following up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

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 99.2% which was higher than other practices in the CCG, and again there was a clear policy for following up non-attenders.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey published in January 2015, and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from these sources 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 74% of patients rated the practice as good or very good. Other data included 96% of patients said they had confidence and trust in the last GP spoken with this was comparable to the local CCG average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards and they were mainly positive about the service experienced. All 18 cards had positive remarks about care, attention, and support being excellent. Staff were described as attentive, friendly and helpful. We were told patients received an excellent service from reception staff through to the doctors. However eight of the patients who had completed the CQC comments cards had some negative comments to add. These included the high turnover of GPs, problems with the telephone system and sometimes the reception staff could be less attentive. These comments were not supported by the patients we spoke with on the day of our inspection. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Two spoke of the exceptional care they received when their health was poor. They felt the surgery went beyond the call of duty to ensure their health and well-being.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Privacy 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 and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

On the day of the inspection we highlighted to the practice manager and the registered manager (GP) how conversations at the reception desk could be overheard in the waiting room. We were told they would re-instate the music in the waiting room, immediately. This had not been used recently because of patient feedback. Some had not liked the music.

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

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 GP patient survey showed 85% of practice respondents said they were sufficiently involved in making decisions about their care when consulting their GP.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. 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 very positive and aligned with these views.

We saw anonymised care plans for patients with long term conditions, detailing their involvement and agreement to life style changes where necessary; we saw appointments for reviews had been arranged.

Staff told us that translation services were available for patients who did not have English as a first language and this had been used occasionally.

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

Good

Are services caring?

spoke with on the day of our inspection and the comment cards we received were also consistent with this information. Other examples of emotional care and support were identified to us by very appreciative patients; who could not praise the GPs highly enough.

Staff told us that if families had suffered a bereavement, they were contacted. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Notices in the patient waiting room, and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs and nurses if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice had identified a named person to support carers and co-ordinate any support required.

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 patient'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 in the way services were delivered.

The NHS England 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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. This included the six federated GP practices who had looked at the service provision of voluntary support in this semi-rural area and had won funding to ensure an up-to-date information about these services was available. The local volunteer service would take referrals and support patients in need to access the most appropriate service or support for them.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. These included reviews of the appointment systems, changes had been implemented and further changes were in the pipe-line for September.

Tackling inequity and promoting equality

The consulting rooms were on the ground floor. Consulting rooms and corridors were accessible to patients which made movement around the practice easy and helped to maintain patients' independence. Patients with mobility limitations were seen in the clinical rooms where access was most suitable for them. We saw the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. The seats in the waiting area were of different heights and sizes allowing for differences in physical health. An audio loop was available for patients who were hard of hearing. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Records showed regular tests were carried out on the emergency call bell facilities. Disabled parking was available for patients.

The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

Access to the service

Appointments were available at the main surgery, Monday to Friday from 8.00am to 11am and 15.20 to 6.00pm. Extended hours were available on Monday evenings until 19.30 and from 7.00am on Tuesday mornings. The practice closed between 1.00pm and 2.00pm each day. Micklefield surgery is open Monday to Friday from 08.30 -11.45 and is open Monday and Wednesday afternoons from 15.20-18.00. Thorpe Willoughby surgery is open Monday to Friday from 08.30 – 11.45.

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

Longer appointments were available for patients who needed them and for those with long-term conditions. This included appointments with a named GP or nurse. Home visits were made to the local care homes each week, by a named GP and to those patients who needed one. Appointments were made available for children of school age after school hours.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed patients in urgent need of treatment had been able to make appointments on the same day when contacting the practice. We also found appointments were available on the day of our inspection and for the next day.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

We saw information displayed in the waiting rooms, in the practice leaflet and on the practice website to help patients understand the complaints system. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found they had been dealt with in a timely way and the practice had been open and transparent when investigating them. There was an active review of complaints and where appropriate improvements made as a result. Positive feedback from patients was also shared and celebrated among the staff.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice vision and values were known by the staff members we spoke with. The values included: openness, fairness, respect, care and accountability.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive on any computer within the practice. We looked at 10 of these policies and procedures. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and there was a named GP as the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice 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 an on-going programme of clinical audits which it used to monitor quality and their systems to identify where action should be taken. These included reviews of emergency contraceptive care in line with national referrals triggered by national guidance alerts. The audit found the practitioners were following best practice.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. We saw the risk log had been recently updated and was regularly discussed at team meetings. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us 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, such as confidentiality which was in place to support staff. We were shown the electronic staff handbook that was available to all staff, it included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. However we were told a new system was being implemented to make these documents and policies more readily accessible to staff.

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

The practice had gathered feedback from patients through patients' surveys, 360 degree feedback (each GP when revalidated is expected to provide evidence of feedback from colleagues and patients) and the friends and family test which was available in the waiting area. The practice was actively looking for ways to improve communication with the whole practice population. Patients who attended the practice or who accessed the website were able to see changes which were being implemented. The practice wished for all patients to be made aware and was looking for ways to achieve better communication.

The practice had an active virtual patient participation group (PPG). The PPG included representatives from various population groups. The PPG had put forward a plan to meet and to identify a chair for the group. This was supported by the practice and we were told by the members of the PPG we met, it would help them formalise information they received from patients within the villages. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results were available on the practice website.

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

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw regular appraisals took place. We were told and were provided with examples where staff had been supported to complete additional training. This was to support their professional development and also enhance the care offered to patients. There was evidence of succession planning throughout the practice. Staff told us of the support and protected time they received when developing new skills.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.