Dr RM Jaggs-Fowler and Partners

Quality Report

Central Surgery,
King St,
Barton Upon Humber,
DN18 5ER
Tel: 01652 636600
Website: www.centralsurgery-barton.co.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
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 this comprehensive inspection on 18 February 2015.

Overall, we rated this practice as good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- The practice provided a good standard of care, led by current best practice guidelines.
- The practice was able to evidence low rates of emergency admissions to A&E, and low use of out of hours services.
- Patients told us they were treated with dignity and respect.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The risk of infection was kept to a minimum by systems such as the use of disposable sterile instruments.
- The practice had appropriate systems of clinical audit and could evidence learning from these.
- The practice proactively sought to register carers to ensure they were offered sufficient support.

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

The areas where the provider must make improvements are:

- Ensure there are systems in place to safely manage the dispensing of medicines in accordance with relevant legislation.

In addition, the provider should:

- Ensure action and learning points from significant events are documented, to ensure that learning opportunities are not missed.
- Ensure all necessary risk assessments are documented, such as risks to patients using the building, or for lone working.
- Ensure all staff are brought up to date with their appraisals.

Summary of findings

- Provide all necessary staff with training around the Mental Capacity Act.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there was an area where it should make improvements. The system for dispensing medicines to patients was not in line with regulations or best practice guidance, as prescriptions were not signed before dispensing and supply to the patient. Staff understood their roles and responsibilities in raising concerns, and reporting incidents. The practice carried out reviews and investigation of incidents with relevant staff, although recording of action points and wider staff participation could be improved. The practice had assessed risks to those using or working at the practice and kept these under review, although these were not always fully documented. The practice was able to evidence how they had responded efficiently to emergency incidents or safeguarding concerns in the past. There were sufficient numbers of staff with an appropriate skill mix to keep people safe. Risks to safety from changes in demand or disruption to service were assessed, planned for and managed effectively.

Are services effective?

Good

The practice is rated as good for providing effective services. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and people's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate, although not all clinical staff had received Mental Capacity Act training. Staff had received training appropriate to their roles, and further learning was supported. Clinical staff undertook clinical audits and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. The majority of feedback gathered through the inspection process was positive, with patients stating they were treated with compassion, dignity and respect, and involved in their treatment and care. The practice buildings were accessible. Information to help patients understand the services available was easy to understand. We also saw that staff maintained confidentiality when dealing with patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had a good overview of the needs of their local population,

Summary of findings

and had engaged with the Clinical Commissioning Group (CCG) and secured service improvements where these were required. The practice had good facilities and was well equipped to meet patient need. Information was provided to help people make a complaint, and there was evidence of shared learning with staff. The practice actively initiated and reviewed changes in areas of patient dissatisfaction, such as the introduction of Rapid Access Clinics to ensure urgent appointments were available the same day. Appointments could only be pre-booked in response to specific need, such as for carers or those with mobility issues.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a long standing visible management team, with a clear leadership structure. Staff generally felt supported by management, with GPs having different lead roles. The practice had aims and objectives contained within their statement of purpose. There were systems in place to monitor quality and identify risk. The practice had an active patient forum and was able to evidence where changes had been made as a result of feedback.

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. The practice held multi-disciplinary meetings to discuss those with chronic conditions or approaching end of life care. The practice had identified those patients of being at risk of an unplanned admission to hospital, and their needs were kept under review. The over 75's had a named GP. Information was shared with other services, such as out of hours services. Nationally reported data showed the practice had good outcomes for conditions commonly found in older people. The practice visited nursing homes in its area weekly.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were appropriately monitored, and were involved in making decisions about their care. Nurses communicated with a clinical lead GP for each condition. The practice was providing extra training for some clinical staff in extra specialist areas to work towards providing multi-condition clinics. Attempts were made to contact non-attenders to ensure they had required routine health checks.

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 to identify children who may be at risk. For instance, the practice monitored levels of children's immunisations and attendances at A&E. Appointments were available outside of school hours and the premises were suitable for children and babies. There were designated mother and baby clinics. Full post natal and 6 week baby checks were carried out by GP's.

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). Patients could access appointments on the day, either through a routine appointment or Rapid Access Clinic, although a lack of pre-booked appointments was a source of some patient dissatisfaction. However, telephone appointments were available, as were

Summary of findings

appointments outside of work hours. Appointments could be booked online, with the first and last slots of each day reserved for these, to support the working population. Repeat prescriptions could be ordered online.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. Patients or their carers were able to request longer appointments if needed, and the practice proactively sought to identify carers. The practice had a register for looked after or otherwise vulnerable children and also discussed any cases where there was potential risk or where people may become vulnerable. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns. There was a home delivery service for medication for those who may struggle to access the service.

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). Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. For instance, 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had an agreed care plan documented in the preceding 12 months. The practice had a mental health clinical lead who was responsible for overseeing services to patients with mental health problems.

Summary of findings

What people who use the service say

We spoke to six patients during the inspection. We also collected 27 CQC comment cards which were sent to the practice before the inspection for patients to complete.

The vast majority of feedback collected on the day indicated patients were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. There was a minority of negative feedback around difficulty seeing the doctor of choice, and general difficulty getting an appointment, both due to not being able to forward book appointments.

In the most recent NHS England GP Patient Survey 68% of patients reported their overall experience as good or very good (below the national average at 85.7%). 88% of respondents say the last GP they saw or spoke to was good at listening to them, which was average for the area. 93% of respondents said they had confidence and trust in the last nurse they saw or spoke to, and 90% had confidence and trust in the GP they saw.

The areas of least satisfaction were in how many people found it easy to get through on the phone (47% of respondents, below the local average of 70%). 49% of respondents described their experience of making an appointment as good, which was lower than the local average of 72%, and 32% of patients indicated they could usually get to see or speak to their preferred GP, below the local average of 53%.

Areas for improvement

Action the service MUST take to improve

- Ensure there are systems in place to safely manage the dispensing of medicines in accordance with relevant legislation.

Action the service SHOULD take to improve

- Ensure action and learning points from significant events are documented, to ensure that learning opportunities are not missed.
- Ensure all necessary risk assessments are documented, such as risks to patients using the building, or for lone working.
- Ensure all staff are brought up to date with their appraisals.
- Provide all necessary staff with training around the Mental Capacity Act.

Dr RM Jaggs-Fowler and Partners

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 specialist advisor GP, and a Practice Manager.

Background to Dr RM Jaggs-Fowler and Partners

Dr RM Jaggs-Fowler and Partners is a large practice providing general medical services (GMS) to approximately 16,600 patients. The main surgery is situated in the town centre of Barton upon Humber but the catchment area covers outlying villages. The practice runs surgeries from Goxhill village daily and Ulceby village on Tuesdays. The Barton upon Humber surgery has the facility to dispense medicines to people who reside in the outlying villages.

There are ten GPs, six partners and four salaried, five female and five male. Patients can be seen by a male or female GP as they choose. There is a team of, one nurse practitioner, seven practice nurses, and five healthcare assistants. They are supported by a team of management, reception, dispensing and administrative staff.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury. The practice population aged less than 39 years is lower than the England average, and has higher levels of older people aged 60 and above. The practice is in a comparatively less deprived area than the average for the NHS North Lincolnshire Clinical commissioning Group (CCG). Out of Hours services are provided via the NHS 111 service.

The CQC intelligent monitoring placed the practice in band one. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our inspection programme. The provider was selected at random from the CCG area.

We carried out the inspection 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.

Detailed findings

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed information the practice provided before the inspection. We carried out an announced inspection on 18 February 2015.

We reviewed all areas of the main surgery including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GP's, nursing staff, healthcare assistants, and administrative, dispensing and reception staff.

We observed how staff handled patient information received from other services and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, and complaints, some of which were then investigated as significant events.

Prior to inspection the practice gave us a summary of significant events from within the last 12 months. The information showed that the practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

GPs told us they completed incident reports and carried out significant event analysis as part of their practice meetings. We saw examples where the practice had reported incidents to the Clinical Commissioning Group (CCG) where appropriate.

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

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed at partner meetings, and the information then shared across the practice as learning points. Staff could access feedback directly via the intranet, staff meetings, or verbally if it concerned them directly. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Incident forms were available on the practice intranet and staff knew how to access these.

We could see from a summary of significant events that where necessary the practice had communicated with patients affected to offer a full explanation and apology, and told what actions would be taken as a result. The practice could demonstrate where changes had taken place as a result of an incident, such as additional procedures to check patient identity at consultations or review of triage protocols.

We did find however, that learning points and actions were not always sufficiently documented, which meant that some learning opportunities could be missed. For instance, after a previous emergency incident, it was recognised that staff needed to be refreshed in emergency procedures, however this did not lead to production of written emergency procedures for staff to follow.

National patient safety alerts were disseminated by email or via the intranet, and staff were able to give recent examples of alerts relevant to them and how they had actioned them, such as changes to medication guidance.

Reliable safety systems and processes including safeguarding

The practice could evidence how they had raised safeguarding concerns to the Local Authority safeguarding team and communicated with other healthcare providers through their incident recording process.

The practice had 'child protection' and 'vulnerable adult' policies and procedures in place, which contained contact details for local safeguarding authorities, although these had not been reviewed since June 2013. Staff could access these policies via the intranet, and also had access to policies produced by the local safeguarding authority.

Information was available to staff about identifying, reporting and dealing with suspected abuse. Staff knew how to access this. Staff were able to described types of abuse and how to report these.

The practice had a named safeguarding lead, who staff were able to identify. Most staff had been given training in safeguarding children and adults at a level appropriate to their role, although some members of staff, including GPs were overdue for refresher training or were unable to provide certificates. The practice manager was sourcing training dates.

The practice had a register for looked after or otherwise vulnerable children. The computerised patient plans were used to enter codes to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. The practice had systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E. The practice had

chaperone guidelines, and there was information on this service for patients in each consulting room, although there was not a chaperone poster to advertise this service in reception.

Staff files showed that candidates were only offered a position following receipt of references, satisfactory Disclosure and Barring Services (criminal records) checks, proof of identity and completed checks on professional qualifications, although there was no written recruitment policy in place.

Medicines Management

Medicines stored in the practice were kept securely and could only be accessed by appropriate staff.

We checked medicines stored in the fridges and found these were stored appropriately. Daily checks and monthly audits took place to make sure refrigerated medicines were kept at the correct temperature, and it was documented where maximum temperatures had been exceeded, for instance because the fridge was being restocked. Procedures were in place to transfer refrigerated medicines in cool bags to the branch site, although there was not a system to log times out and in, therefore the practice could not verify how long medicines had been not held at a controlled temperature.

We saw evidence that the doctors bags were regularly checked to ensure that the contents were intact and in date. Processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Prescriptions were stored securely.

Vaccines were administered according to directions that had been produced in line with legal requirements and national guidance. Members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. Standard operating procedures were in place which staff followed.

We did find however, that the system for dispensing medicines to patients was not in line with regulations or best practice guidance. Repeat and newly issued prescriptions were dispensed to the patient before the GP had checked the prescription. These were then collated by the dispensing staff for the GP to sign the next day. Newly generated prescriptions should ideally be signed before dispensing to the patient, or at least at the end of the same day. Prescriptions written by GPs during consultations (acute prescriptions) were sent electronically to the dispensary. Whilst it is preferable for such prescriptions to be printed and signed before medicines are dispensed, sending prescriptions electronically provides an audit trail confirming the GP has authorised the medicines. Following the inspection the provider sent us new written procedures for prescriptions to be checked in accordance with regulations.

Repeat prescriptions should be checked and signed before dispensing to the patient. Repeat prescriptions requested by patients were printed electronically by staff in the dispensary. We found that it was custom and practice for repeat prescriptions to be dispensed and the medicines given out before prescriptions were signed by a doctor. Staff were unable to explain how they would allocate prescriptions to be signed if the GP, for instance a locum doctor, was not present the following day. This system meant that a prescribing error would potentially not be noticed until after the patient had received the medicine and started to take it. GPs reviewed their prescribing practices and trends at least annually, or as and when medication alerts were received. There was a GP prescribing lead who oversaw prescribing practices and alerts, including looking to reduce unnecessary medications.

Cleanliness & Infection Control

We observed all areas of the practice to be clean, tidy and well maintained. Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC), waste disposal and legionella testing policies, which were being reviewed and updated. There was an identified IPC lead.

We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place. Cleaning was carried out by staff employed by the practice. The lead domestic

showed us cleaning checklists and schedules which staff worked to, which were then audited by the infection control lead. Public toilets were observed to be clean and have supplies of hot water, soap, and paper towels.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment such as blood pressure monitors used in the practice was clean.

We saw evidence that staff had their immunisation status for Hepatitis B checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Regular infection control audits were carried out by the lead staff member, and the findings communicated to staff. The practice had a planned programme of improvement, such as updating all curtains to a disposable type as consulting rooms were refurbished.

Equipment

We found that equipment such as scales, spirometer and fridges were on external contracts to be checked and calibrated on a timely, regular basis to ensure they were functioning correctly. Regular external checks were carried out on equipment such as fire extinguishers and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager and administration staff.

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

The practice manager was able to describe the recruitment process to be safe and prevent discrimination, although there was not a written recruitment policy in place.

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 there was 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.

The practice manager showed us how rotas were planned in advance to take into account periods where demand may fluctuate, for instance after bank holidays. The practice had recently recruited more nursing and reception staff. Staff told us there were enough staff to maintain the smooth running of the practice and keep patients safe.

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately.

There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks, for instance maintenance checks, checks of the fire alarm system and fire equipment. Although risks to patients using the building had been considered, there were no written risk assessments in place for this to ensure these remained under review and up to date, so patients using the service were not exposed to undue risk.

There were health and safety policies and a staff safety handbook in place covering subjects such as fire safety, manual handling and first aid. These were kept under review to monitor changing risk.

Patients with a change in their condition or new diagnoses were reviewed appropriately, which allowed clinicians to monitor treatment and adjust according to risk. Staff gave examples of how they responded to patients changing needs, for instance someone experiencing a mental health crisis, including supporting them to access emergency care and treatment. Information on patients was made available to out of hours providers as required so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming that most staff had received Cardio Pulmonary Resuscitation training, although records could not be supplied for a minority of staff.

Staff could describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose, although there were no written emergency procedures. We saw from incident records where staff had responded to previous emergencies.

A business continuity plan was in place which had been reviewed, which included details of scenarios they may be needed in, such as loss of data or utilities. If required the practice could relocate to one of the branch surgeries or a local school to continue operating. Fire drills were held every six months and regular fire safety checks were carried out.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. Processes were in place to check emergency medicines were within their expiry date. Emergency oxygen and a defibrillator were available, which were regularly checked and serviced.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Clinical Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into their practice and disseminated via email.

Treatment was considered in line with evidence based best practice. Clinical meetings were held monthly to ensure clinicians were kept up to date, in addition to monthly palliative care meetings and bi-monthly multi-disciplinary meetings to discuss those at risk or with complex needs. The practice had higher levels of patients than the England average stating they had a long term condition or caring responsibilities.

All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge, with GPs given two weeks study leave per year to maintain their knowledge. Nurses worked alongside GPs within their guidelines for their area of chronic disease management, and discussed patients' needs before the GP prescribed. GPs maintained lead areas of special interest and knowledge, such as mental health, respiratory health and diabetes.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates, and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. For instance, the practice was facilitating additional training for some nursing staff to develop multi-condition clinics for patients, where people with more than one long term health condition could be seen by one person in one longer appointment rather than having to visit the surgery multiple times.

All GP's we spoke with used national standards for referral, for instance two weeks for patients with suspected cancer to be referred and seen. The practice could produce a list of those with learning disabilities or who were in need of palliative care and support. Patients requiring palliative care were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. Latest QOF data from 2013-14 showed the practice had an overall rating of 97.6%, above the CCG and England averages.

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area, for instance the practice looked at referral rates and A&E admissions and compared these against criteria. This benchmarking data showed the practice had good outcomes comparable to other services in the area.

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). For instance, one audit was carried out on the use of broad spectrum antibiotics, which had been reduced in line with national guidance. Examples of other audits included the use of warfarin or drugs to lower cholesterol. Audits set out the reason for the study, criteria and standards to look at, and findings. A future date was included for re-audit to gauge the success of any corrective actions.

Clinical staff 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

Good

Are services effective?

(for example, treatment is effective)

system flagged up when patients needed to attend for a medication review before a repeat prescription was issued, and when people needed to attend for routine checks related to their long term condition.

Effective staffing

The practice manager oversaw a training matrix which showed when essential training was due. Training was provided through variety of means including external CCG events, internal training and e-learning. Staff told us the practice was supportive of relevant professional development.

GP's told us they had undertaken annual external appraisals and had been revalidated or had a date for revalidation, an assessment to ensure they remain fit to practice. Continuing Professional Development for nurses was monitored through the appraisals process. Professional qualifications and medical indemnity insurances were checked periodically.

Staff were appraised annually which generated aims and objectives for staff, with staff able to feed back any problems and what they did well. There was a system for clinical staff to be appraised by their senior member of clinical staff; however reception staff had not been appraised since September 2013. The reason given for this was workload issues. There was no date scheduled for these appraisals. Non clinical staff we interviewed said they valued the appraisals as they felt they would help improve communication and give them a chance to raise issues.

Relevant checks were made on qualifications and professional registration as part of the process. On starting, staff commenced an induction comprising health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff.

We saw that mandatory training for clinical staff included safeguarding and infection control, although the practice could not supply records to show that all members of staff were up to date with required training, for instance six members of staff did not have a record of basic life support training. Staff had access to additional training related to their role. Staff said they generally felt confident in their roles and responsibilities. There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff, which were available to staff through the staff handbook.

Working with colleagues and other services

The practice Statement of Purpose contained a specific aim to provide high quality care in conjunction with other health and social care providers, for instance other practices, secondary care and community services.

The practice worked with other service providers to meet people's needs and manage complex cases, for instance regular multi-disciplinary meetings were held to identify and discuss the needs of those requiring palliative care, or those who would require it. These were attended by district nurses and social services as necessary, although the practice did not routinely communicate with health visitor, which they were seeking to address through the CCG.

Health monitoring of patients with long term conditions was discussed at regular clinical meetings between GPs, to discuss and review treatment strategies and any required actions or changes. The practice worked closely with the CCG, with a number of partners having roles at the CCG, and attended information sharing meetings in the region.

Information from out of hour's services and NHS 111 contacts was disseminated to GPs to review the next working day so that any required action could be taken, with a mechanism for urgent clinical matters to be faxed and reviewed by a duty doctor. The practice used a 'contact form' to share information on palliative care patients with the out of hours service. The practice kept 'do not resuscitate' and advance decision registers to reflect patient's wishes, and this information was made available to out of hours providers.

Blood results, discharge letters and information from out of hours providers was generally received electronically or by fax and disseminated to the named GP or duty doctor. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

The practice had recently developed links with a local Befriending Service, which offered support to older people living alone. The practice identified patients who could benefit from the service then contacted them to inform them of the service and how they could get in touch.

Information Sharing

Information was shared between staff at the practice by a variety of means. There were management and clinical meetings. Team leaders fed back to their own staff from these meetings. Staff were able to describe how they

received information via meeting minutes, the intranet, or emails. Staff said they found communication within their own teams generally good, although they did not always feel fully involved and aware of what was happening in the practice as a whole.

Referrals were completed through a number of standard templates to use for referral to different clinical specialities, and these were completed within appropriate protocols. There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. Urgent information could also be sent or received via fax. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that GPs and some clinical staff had received training on the Mental Capacity Act 2005, and were able to describe key aspects of the legislation and how they implemented it. However, some clinical staff such as healthcare assistants had not received this training, who were carrying out procedures such as taking blood from patients with dementia or learning disabilities.

However, staff were able to discuss the carer's role in the decision making process. 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. Verbal consent was documented on the computer as part of a consultation. Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, which allowed patients to make an informed choice.

GPs demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

GPs explained where people had recorded advance decisions about their care or their wish not to be resuscitated this was recorded in their notes. Where those with a learning disability or other mental health problems were supported to make decisions, this was recorded. If someone had lasting power of attorney concerning a patient this was recorded on the computer and in the patients plan.

There was a practice policy on consent to support staff and staff knew how to access this, and were able to provide examples of how they would deal with a situation if someone did not have capacity to give consent, including escalating this for further advice to a senior member of staff where necessary.

Health Promotion & Prevention

Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. Patients over the age of 75 had been allocated a named GP. Nurses used chronic disease management clinics for conditions such as asthma and diabetes to promote healthy living and health prevention in relation to the person's condition, such as healthy eating advice.

Patients aged 40-74 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. New patients were offered health checks. The practice could identify patients who needed additional support. For example, the practice kept a register of all patients with a learning disability or those with palliative care needs. Patients with a learning disability were offered an annual physical health check.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The percentage of patients aged 65 and older who had received a seasonal flu vaccination was slightly above the national average. There were family planning and baby clinics where people could access a number of services, and a walk-in sexual health clinic provided once a week from the surgery by an external organisation. Patients could also access a counselling team who attended at the practice. The practice website gave information on available clinics and health promotion.

The practice's performance for cervical smear uptake was above the national average. There was a policy to follow up patients who did not attend for cervical smears.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke to six patients during the inspection. We also collected 27 CQC comment cards which were sent to all three sites of the practice before the inspection for patients to complete. The vast majority of feedback collected on the day indicated patients were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable.

In the most recent NHS England GP Patient Survey 88% of respondents say the last GP they saw or spoke to was good at listening to them, which was average for the area. 93% of respondents said they had confidence and trust in the last nurse they saw or spoke to, and 90% had confidence and trust in the GP they saw.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, and a notice in each consulting room advertising the service to patients, although not in reception. Nursing staff or other trained staff acted as chaperones where requested. GPs noted when someone had been offered a chaperone and refused the service.

Office space behind the reception desk was shielded by glass partitions to promote privacy for phone calls. A system was in place to encourage patients to approach the desk one at a time, to help prevent patients overhearing potentially private conversations between patients and reception staff. There was a separate room where patients could speak in private if they wished. Patients we spoke to on the date did not raise privacy in reception as an issue.

Care planning and involvement in decisions about care and treatment

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care, and nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin. Nurses had access to literature for the patient's condition, such as healthy eating for diabetics, and nursing staff explained how patients were encouraged to ask questions and learn about their condition.

In the most recent NHS England GP Patient Survey, 70% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care, while 81% said the last nurse they saw or spoke to was good at explaining tests and treatments.

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 generally positive and aligned with these views.

People said the GP's explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us there was an online translation service available for those whose first language was not English, however staff stated their awareness of this service was low due to low demand in the area.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service. In the most recent practice survey, 88% of patients said they were happy with how the GP had listened to them.

GP's referred people to bereavement counselling services where necessary, and there was information about support services in reception. A counselling service operated from the building so was convenient for patients to access. Where people had suffered bereavement, GPs told us they would contact the next of kin. Carers were recorded in patient notes so extra support could be offered, with patients being asked opportunistically whether they had caring responsibilities to allow them to be registered.

Good

Are services caring?

The practice kept registers of groups who may need extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided.

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.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities, with several GPs having roles within the CCG.

Longer appointments could be made available for those with complex needs, for instance patients with diabetes. The practice was facilitating additional training for some nursing staff to provide multi-condition clinics so patients did not have to attend the surgery multiple times for each condition they had.

Telephone consultations and a home delivery service for medication were available, to help patients who lived in rural areas or may otherwise struggle to access the surgery.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow these up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

GPs told us the practice made weekly visits to each of the major care homes where patients were seen by their regular GP.

Tackling inequity and promoting equality

The buildings accommodated the needs of people with disabilities. All treatment/consulting rooms and patient toilets were on the ground floor. Disabled parking spaces were available. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

There was a practice information leaflet available, covering subjects such as services available, staff list, and how to book appointments, although there were not copies of these available in reception when we arrived. There was a hearing loop at reception to assist those hard of hearing.

The practice had recognised the needs of different groups in the planning of its services. Patient records were coded to flag up to GPs when someone was living in vulnerable circumstances or at risk so extra support could be offered.

Access to the service

The appointments system was book on the day, however once a patient was recognised as having specific needs, for instance because they were a carer, or had mobility issues, a reminder was put on their patient record home screen to allow receptionists to identify when they could forward book a patient to allow them to plan. Calls were also triaged to ensure urgent appointments were made available after routine appointment slots were full.

When all routine appointments for that day have been taken, patients were offered the opportunity to join the Rapid Access Clinic list at 11.30am. All doctors who were on duty that day saw patients in-turn from the list until each patient had been seen. Telephone appointments were also available.

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.

Appointments could be made in person, by telephone or online. Online appointments available were the first and last slots in each day to help those who could not access during the day, for instance the working population. Home visits could be made available where assessed as required through a triage system, for instance for those with mobility issues of learning disabilities. Repeat prescriptions could be ordered online or by telephone. The practice promoted its online services on the website.

The main surgery had core hours of 8:00am until 6:30pm, Monday to Friday. There were also two part-time village branch surgeries, Goxhill which was open from 8:00am until 1:00pm, then 2:00pm until 6pm Monday to Thursday, 4pm

Good

Are services responsive to people's needs?

(for example, to feedback?)

on Friday. Ulceby village surgery was open 2:00pm until 4:00pm on a Tuesday, by appointment only. Opening times and closures were advertised on the practice website, with an explanation of what services were available.

During core times patients could access a mix of doctors, nurse practitioners, nurses & health care assistants, or clinics such as family planning and for chronic conditions. Patients we spoke with told us their appointments generally ran to time. The most common negative from patients was difficulty accessing appointments with the GP of their choice, and difficulty with not being able to forward book appointments.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was displayed in reception and on the website, and staff were able to signpost people to this.

We looked at a summary of complaints from the last 12 months, and could see that these had been responded to with a full explanation and apology. Information on how to make a complaint was available in a practice leaflet, and there was a suggestion box in reception where patients could leave feedback. Patients could also access a link to the Friends and Family Test via the practice website.

The practice summarised and discussed complaints with staff at practice or clinical meetings, with some raised as significant events, and was able to demonstrate changes made in response to feedback, such as changes to the appointment system. People we spoke to said they would feel comfortable raising a complaint if the need arose.

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 developed a statement of purpose with a number of aims and objectives setting out what they wished to achieve. These included auditing performance against key targets and core standards, and regular monitoring of clinical outcomes.

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The partners held regular meetings to analyse how they thought the practice was performing, problem areas, and opportunities and threats for the future, although this was not recorded as a business plan with medium and long term objectives. Although some staff thought the practice had a mission statement, they were unclear as to what it contained.

Governance Arrangements

Staff were clear on their roles and responsibilities, and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. A number of staff had specific lead roles such as infection control, and management of specific conditions. Each GP, including salaried doctors, were encouraged to take on a lead role, such as health and safety or safeguarding.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed was performing in line or above national standards in most areas, and the practice regularly reviewed its results and how to improve. Each GP oversaw a specific area of the QOF. There was a programme of clinical audit, mainly subjects selected from QOF outcomes or the CCG. Audits on subjects such as infection control, antibiotic prescribing and use of high risk medicines were recorded, and included a date for re-audit.

From our discussions with staff we found that the service used data from various sources including incidents, complaints and audits to identify areas where improvements could be made.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care. Staff said they felt confident in raising concerns or feedback, but a number of staff said they felt whole practice communication could be improved, and help them feel more involved in the staff team as a whole.

There was a clear chain of command and organisational structure. There was a staff handbook with human resources policies for instance disciplinary and grievance procedures, which were in place to support staff.

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

There was an active Patient Reference Group (PRG), and patient survey results published on the practice website for the practice population to read.

The practice carried out a patient survey in November 2013, which generated 350 responses. The practice identified common themes in feedback and produced 'You said- We did' information where a number of changes had been made as a result of feedback. These included employing two new doctors, allowing patients to contact the branch surgery directly, and access improvements.

Suggestion boxes were available and the practice website signposted patients to the 'friends and family' test where they could leave feedback. The practice produced an annual newsletter, which patients could pick up at the surgery, from local pharmacies, the library, or access through the website.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. There was a whistleblowing policy which was available to all staff.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to access protected learning time where necessary. We saw that appraisals took place where staff could identify learning objectives and training needs.

The practice had completed reviews of significant events and other incidents, and shared these with staff via team meeting discussions to ensure the practice improved outcomes for patients.

Are services well-led?

Good

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

The practice had signed up to the Productive General Practice programme, a CCG led innovation to encourage improvement and efficiencies, and was looking to start project work on appointment demand and how this could be better managed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **How the regulation was not being met: The practice did not have systems in place to safely manage the dispensing of medicines.**