Dr KK Masson & Dr H Masson

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

On 02 December 2014 we carried out an announced inspection of Dr K K Masson and Dr H Masson, Grays, Essex under our new approach of inspection of primary medical services.

We found that the practice was good overall across all the areas we inspected.

Our key findings were as follows:

- Practice staff were kind and caring and treated patients with dignity and respect.
- The practice was safe for both patients and staff. Robust procedures helped to identify risks and where improvements could be made
- The clinical staff at the practice provided effective consultations, care and treatment in line with recommended guidance.
- Services provided met the needs of all population groups.
- The practice had strong visible leadership and staff were involved in the vision of providing high quality healthcare.

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 practice was able to demonstrate that they provided safe services that had been sustained over time. There were processes in place to report and record safety incidents and learn from them. Staff were aware of the systems in place and were encouraged to identify areas for concern, however minor. Staff meetings and protected learning time were used to learn from incidents and clear records had been kept including any action taken. Risks to patients were assessed and well managed. Infection control procedures were completed to a satisfactory standard. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Clinical Excellence (NICE), acted upon updates and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. The performance of the practice across key health areas was regularly monitored to ensure it achieved targets. Health promotion advice was readily available and patients signposted to external organisations to receive support. Staff were supported in the workplace, received annual appraisals to measure their competence and were trained appropriately. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff worked with multidisciplinary teams to ensure patients received the best care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients we spoke with and those who had taken part in surveys, said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information was available at the practice that helped patients understand their condition and the services that were available to them externally. Staff treated patients with kindness and compassion and treated information about them confidentially. Patients with caring responsibilities were supported.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They were aware of their practice population and tailored their services

Summary of findings

accordingly. Patients were generally satisfied with the appointment system and the availability of the GPs and the nurse. Patients had a choice of GP if they wanted one. Telephone consultations and home visits were available when necessary. The premises were suitable for patients who were disabled or with limited mobility. A prescription service was available for those patients unable to attend the practice and a local pharmacy made home deliveries. There was an effective complaints system in place that was fit for purpose, although no complaints had been received.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy for the delivery of high quality care and staff were working towards it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular team meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events. An ethos of learning and improvement was present amongst all staff.

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. It was responsive to their needs. Home visits and priority for appointments was available and prescriptions could be delivered to their home addresses by a local pharmacy. The practice adopted the Gold Standards Framework for the treatment of people nearing the end of their lives and requiring palliative care. Multi-disciplinary team meetings took place for elderly people with complex needs. External support was signposted and made available for them to access. Elderly patients had a named GP to receive continuity of care. Home visits and telephone consultations were available. The practice was pro-active in encouraging patients to receive flu vaccinations. Patients could obtain repeat prescriptions when they were required. Adult safeguarding procedures were in place to protect elderly vulnerable patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Emergency processes were in place and referrals were made for patients whose health deteriorated suddenly. Telephone consultations and home visits were available when needed. The nurse provided services to ensure patients could receive support and advice in relation to their condition and had received specialist training. Their conditions were regularly monitored to ensure the care and treatment was effective. Patients were the subject of regular review and other healthcare professionals were routinely involved.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There was an effective system in place to monitor and report children who might be vulnerable to abuse. Targets for national childhood immunisation rates were being achieved. Staff were aware of consent and mental capacity issues in relation to teenage children. The premises were suitable for children and babies and a mother and baby changing room was available. Appointment availability met the needs of mothers and babies and children with emergencies were prioritised. Antenatal care was referred in a timely way to external healthcare professionals. Mothers we spoke with were positive about the services available to them at the practice.

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 people (including those recently retired and students). Patients we spoke with were satisfied with the consultations, care and treatment provided. The appointment system met their needs generally, but some patients commented that there were no late evening appointments and routine appointments were not always available. Appointments could be booked on-line. Health promotion advice was readily available with the nurse and including smoking cessation, healthy eating and alcohol consumption.

People whose circumstances may make them vulnerable

Good

Double appointment times were offered to patients who were vulnerable or with learning disabilities. All patients were able to register at the practice as temporary residents, regardless of their personal circumstances, including the homeless and members of the travelling community. If necessary patients could be referred to a local walk-in centre if they could not obtain an appointment. Carers of those living in vulnerable circumstances were identified and offered support including signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. A lead for safeguarding monitored those patients known to be at risk of abuse. All staff had been trained in safeguarding and were aware of the different types of abuse that could occur.

People experiencing poor mental health (including people with dementia)

Good

The practice was aware of the number of patients they had registered who were suffering from dementia and they were offered additional support. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and then on-going monitoring of their condition took place after being discharged back to the GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations such as the mental health charity MIND, the community psychiatric nurse and a local service known as 'Therapy for You' that provided counselling and support.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete about their views of the practice. Unfortunately none had been completed.

Patients spoken with on the day of the inspection were very complimentary about the GPs, practice nurse, practice manager and reception and administration staff. They told us that they were kind and caring and treated them with dignity and respect. They were satisfied with the quality of the consultations and were involved in planning their care and treatment.

The practice had undertaken annual surveys and information was made available to us dating back to 2006. Patients were asked to complete a questionnaire covering a variety of areas about the services available and the results were analysed. The questions included patients' views about the availability of appointments, quality of consultations, explanations of care and treatment options and helpfulness of staff.

The results of the most recent survey from 2013 revealed that a high percentage of patients were very satisfied with the services the practice offered. Where areas for improvement had been identified, the practice made changes where appropriate.

The latest survey revealed that some patients felt that they waited too long to see the GP once an appointment had been given to them. The practice made the GPs aware of this issue to try and reduce the number of occasions this happened. They also implemented other measures such as text message reminders to patients and contacting patients who did not appear for their appointment, in order to reduce the waiting time that patients had experienced.

Dr KK Masson & Dr H Masson

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team also included two specialist advisors, a GP and a Practice manager.

Background to Dr KK Masson & Dr H Masson

The practice known as Dr K K Masson and Dr H Masson is situated in Grays, Essex and is one of 34 GP practices in the Thurrock Clinical Commissioning Group (CCG) area. The practice has a General Medical Services (GMS) contract with the NHS.

Facilities at the practice include a small car park at the rear of the premises with a dedicated parking space for the disabled. A ramp and supporting hand rails are available at the rear entrance to support patients who are wheelchair users or those who have limited mobility.

The practice has two male GPs, one practice nurse, a practice manager, an assistant practice manager and a number of reception and administration staff.

There are approximately 3200 patients registered at the practice.

GP sessions run each day in the morning and afternoon, finishing at 630pm. The practice nurse works part-time but covers a number of sessions throughout the week. The practice is closed at weekends.

The practice have opted out of providing out-of-hours services to their own patients so patients contact the emergency 111 service to obtain medical advice outside of normal surgery hours.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We then carried out an announced visit on 02 December 2014. During our visit we spoke with a range of staff including the GPs, nurse, practice manager, reception and administration staff and spoke with patients who used the service. We observed how people were being cared for and

Detailed findings

reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice.

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)

Good

Are services safe?

Our findings

Safe track record

The practice monitored patient safety using a range of different methods including significant events analysis, complaints, national patient safety alerts and safeguarding adults and children. A Health and Safety checklist also monitored the risks to patients and staff.

Staff we spoke with were all aware of the systems in place at the practice to record incidents involving safety and were encouraged to bring such incidents to the attention of the practice manager or one of the GPs.

We reviewed the significant events that had been recorded in the last 12 months and found that they had been analysed effectively. There was a clear investigation with safety as a priority. Where learning had been identified this had been cascaded at staff meetings and recorded in the minutes. Staff spoken with confirmed that this was taking place and displayed an awareness of the significant events that had occurred.

There had been no complaints in the last 12 months but systems were in place to analyse them for safety issues and to review procedures at the practice. National patient safety and medicines alerts were handled effectively and actioned where appropriate to ensure patients were safe. On receipt of such an alert, they were passed to the GPs for assessment and appropriate action taken.

This showed the practice had managed safety issues 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. We looked at a number of significant events that had occurred in the last few months and found that they had been completed to a high standard. Each event had been recorded accurately including the details of the event, the effect on the patient if relevant, the subsequent analysis and any learning that had been identified. This was then cascaded to staff at team meetings and recorded.

One such significant event identified that a patient was at risk due to a lack of communication between a hospital and the practice. It was identified that the patient concerned was on two medicines that were having an adverse effect on the patient. The practice contacted the hospital and established that one of the medicines should have been stopped but the patient was unaware and documentation received by the practice from the hospital, did not make this clear. As a result of this event, the practice reviewed all the patients on similar medicines and found a trend which they were able to rectify. The practice then provided feedback to the hospital concerned. They then acted on the feedback and changed its procedures to prevent a reoccurrence. This was an example of where the practice, through their investigation, had been able to identify an area for improvement that benefited not only patients at their own practice but also elsewhere.

We looked at the minutes of the staff meetings and found that learning had taken place. Significant events were a standing item on the agenda at staff meetings. Staff we spoke with displayed knowledge of the incidents that had taken place and the learning achieved as a result of them.

Staff were aware of the procedures to follow when reporting a concern, whether it be a significant event or a more minor matter. They told us they were encouraged to report incidents so all could learn from them. We found that there was a positive culture amongst the managers and staff to report incidents to keep both staff and patients safe.

National Patient Safety Alerts were responded to in a timely fashion. GPs were informed of the relevant issues, patient records were updated and changes made to care and treatment where necessary. Alerts were also discussed at team meetings so clinical and non-clinical staff were aware of them.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. A lead for safeguarding had been identified and this was one of the GPs who was trained to level three. This level ensures professionals have met statutory **safeguarding training** requirements. The other GP at the practice was also trained to the same level. All other staff at the practice had received safeguarding training and displayed an awareness of the procedures to follow and the different signs of abuse that could take place. We were provided with proof of training in the form of certificates. These were in date and current.

Good

Are services safe?

Staff told us that they would find it useful to have the names and contact numbers of the local authority safeguarding team and other external agencies that they might need to call in the event of a safeguarding issue. We discussed this with the practice manager on the day of our inspection and they have agreed to provide this for their staff in the reception area.

Staff were not routinely aware of whistle blowing legislation or how to raise a concern either at the practice or with or the various organisations externally that they could alert. The practice has agreed to provide additional training in this area.

The practice carried out an audit annually for those patients on their child protection register. This was undertaken with support from the local authority safeguarding team who checked the record keeping ensuring they were of the required standard. Documents we viewed reflected that the child protection register was being maintained to a high standard.

Patients identified as at risk were appropriately recorded on the computerised patient record system so when they attended for an appointment members of the clinical team were aware and could monitor their safety.

National Patient Safety Alerts and medicine warnings were handled effectively. On receipt of information, the patient record system would be searched to identify which patients may be affected. If necessary, they were then contacted, their care and treatment discussed and changes made or risks explained. Each alert was placed on the patient's record and viewed by one of the GPs who was responsible for initiating any necessary action.

The practice had a Health and Safety Policy which had been recently reviewed. A practice risk assessment had been undertaken which identified safety issues for both staff and patients. These included clinical, buildings, fire, personnel and equipment risks. These were the subject of regular reviews and visual checks that ensured the practice was safe for both patients and staff.

The practice managed test results effectively. Where patients had not contacted the practice and a result showed some adverse outcome, patients were contacted by phone or letter and invited to attend again for a follow-up appointment with a GP. Test results were checked on a daily basis.

There was a chaperone policy, which was available for staff to read. Neither the practice nurse nor other staff had received formal training in the procedures to follow. However when asked about the principles of the role of chaperone, they displayed sufficient knowledge that showed that they understood the action to take when undertaking the role and where to stand during an examination. We also noticed that there was no sign in reception indicating the availability of chaperones and with two male GPs only at the practice, the availability of chaperones should be more widely advertised. The practice manager has agreed to provide more formal training to a selection of staff and to display a sign about the availability of chaperones.

Systems were in place to ensure that young children received their inoculations as part of the national immunisation programme. Patients were pro-actively contacted to ensure they had received their treatment when it was due. Data available to us reflected that the practice was achieving its targets.

Medicines management

The practice met annually with representatives of the Clinical Commissioning Group Medicines Management Team to audit and discuss their prescribing of medicines. This ensured that patients were prescribed the most appropriate medicines for their condition and at the same time providing value for money.

Medicines were reviewed annually or earlier if required, to ensure that patients were receiving medicines that were safe and effective. This included the elderly, those with long-term conditions and patients with learning difficulties and poor mental health. Patients were not issued prescriptions until this review had been carried out. Each prescription was clearly marked to reflect the date of review. If a review was required sooner than annually, this was undertaken.

We checked medicines stored in the practice and the fridges used for storing them. We found they were stored securely and were only accessible to authorised staff. We found that medicines were kept at the required temperatures, which were recorded, and stock was rotated regularly to ensure their use by date did not expire. There was a procedure in place to ensure that when medicines were received, they were placed in the fridge as soon as possible to ensure they did not deteriorate.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use and records were maintained. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with published guidance. The emergency medicines available if patients were taken ill at the practice, were all in date and monitored regularly.

Each GP had a home visit bag that contained appropriate medicines that were all in date. These were checked frequently and stock ordered when necessary.

The practice nurse had received appropriate training to administer vaccines and we saw training certificates that confirmed this.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were stored securely.

Cleanliness and infection control

The practice had identified a lead for infection control and this was the practice nurse. They had undertaken training to enable them to provide advice on the practice infection control policy to other staff members. The infection control policy was stored on computer and a procedure manual was also available for staff to refer to.

All staff received induction training about infection control specific to their role. We saw evidence that the infection control lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. One such audit was an independent one carried out by the Primary Care Trust in 2013. Areas for improvement had been identified, actioned and maintained when the audit for 2014 had been carried out, with no repeat improvement areas identified. Minutes of practice meetings showed that the findings of the audits were discussed.

We found that the premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The responsibility for cleaning the premises was allocated to an external company. There were clear lines of communication between the practice and the cleaners to ensure that quality and standards were maintained and that checklists were adhered to. Records held reflected that cleaning was being undertaken to a satisfactory standard and the quality monitored.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. During our inspection we found that the practice was clean and tidy.

Personal protective equipment including disposable gloves and aprons 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 were aware of the action to take if an incident occurred.

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.

Clinical waste was stored and disposed of in line with recognised guidance. An externally appointed contractor made collections weekly and records had been maintained.

Clinical staff at the practice had received hepatitis B inoculations and the effectiveness of them was monitored regularly. Non-clinical staff had been offered the inoculation on a voluntary basis.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). This is a requirement for employers under Health and Safety legislation. We have asked the practice to ensure that this takes place in the future and they have agreed to implement a risk assessment and testing schedule.

Equipment

We found that there was sufficient equipment in use at the practice to meet the needs of patients. This included disposable medical equipment for use on one occasion only. Equipment in use at the practice included blood/sugar and blood pressure monitors, weighing scales, spirometers and nebulisers.

All equipment was regularly calibrated to ensure it was working correctly. Electrical equipment was the subject of portable appliance testing to ensure it was safe. Records were kept that reflected that these checks were being undertaken on a regular basis.

Good

Are services safe?

There were sufficient quantities of personal protective equipment to keep staff safe. These included aprons and disposable gloves. A system was in place for stock control.

Staff we spoke with told us that they were satisfied with the quality and quantity of equipment made available to them to enable them to carry out their roles in providing examinations, assessments and treatment.

Staffing and recruitment

The practice had a recruitment policy that had been reviewed and was fit for purpose. It explained the process from identifying a vacancy through to employment. It stated the requirement to check people's identities, qualifications and experience and whether they were registered with the relevant professional body. It explained about the interview process and the requirement for a Disclosure and Barring Service check to be undertaken. This replaced the Criminal Record Bureau check and is a combined check to ensure employers make safe recruitment decisions about those they employ. It also included the need to take references and to check on the legal status of people who were applying from a foreign country to ascertain whether they were entitled to work in the UK and had the appropriate skills.

Each new member of staff, including GPs were required to go through an induction process. This involved being made aware of how the practice runs, familiarisation with the patient record system, health and safety information and the expectations and standards that the practice wished to maintain.

The practice had not had to use locum GPs in the last two years but planned ahead in case they needed them. They used an agency who supplied them with full details about the locum to ensure they were suitably qualified and experienced. This also included feedback from other practices that had used them in the past.

Non-clinical staff had been trained in a way that they were able to cover each other's roles through absence due to annual leave, training or sickness. There was a suitable mix of skills and experience of staff to meet the needs of patients. Where staff shortages occurred, because staff were multi-skilled they could interchange roles easily to ensure the practice ran smoothly. We saw that staff numbers were regularly monitored to ensure that enough staff were on duty. Staff told us there were usually enough staff to maintain the efficient running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy and a designated lead for oversight of safety and risk. A practice risk assessment was in place that identified risks to staff and patients and how to minimise or reduce them.

Annual audits of health and safety issues took place and a range of other audits were being undertaken, including prescribing and infection control. Equipment was monitored regularly to ensure it was working correctly and safe to use. Any findings that had been identified were shared with staff at their meetings.

Staff meetings and protected learning time were used to discuss risk with clinical and non-clinical staff and any learning identified was cascaded to them.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Where referrals to specialists were urgent these were actioned the same day so that patients could receive the earliest appointment possible.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency first aid 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 that it was checked regularly to ensure it was fit for use.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether they were within their expiry date and suitable for use. All the medicines we checked were in date.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This was available in both computerised format and a hard copy. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to and they knew how to access it.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire evacuation training. The practice manager acknowledged that there was a need to carry out more regular fire drills and has agreed to action this in the near future. The practice had an intruder alarm linked to the local police station.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse we spoke with were familiar with current best practice guidance, and carried out their assessments and consultations in line with guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We found that clinical staff had a system in place to receive relevant updates about new guidelines that were then put into practice with their patients.

GPs attended training sessions and undertook e-learning modules that provided them with clinical updates so that their learning was continuous. Clinical 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 led in specialist clinical areas such as cancer, mental health and dementia. The practice nurse supported this work but led on diabetes management, chronic obstructive pulmonary disorder, smoking cessation and hypertension.

Patients we spoke with on the day told us that they were very satisfied with their assessments and said that their needs were met by both the GPs and the nurse.

The practice used the appointment system, rather than separate clinics, to manage the ongoing care and treatment for patients with long term conditions. Patients received appropriate advice about the management of their condition including how they could improve the quality of their lives.

Patients were referred to specialists and other services in a timely manner. Where urgent, these were made on the same day but in general within 48 hours.

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

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We looked at several clinical audits on the day of our inspection. An analysis of the findings had taken place and where areas for improvements were identified these had been documented and actioned. Some clinical audits were linked to national patient safety and medicines alerts where the number of patients affected by them was reviewed and changes in medicines made, to improve the outcomes for them.

Non-clinical audits also took place. One such audit took place monthly and monitored the number of patients who did not attend for an appointment. Once a patient had not attended on two occasions, they were written to with an explanation about the impact of this non-attendance on waiting times and other patients.

The practice used the Quality Outcomes Framework (QOF) to monitor their performance against national targets and screening programmes to monitor outcomes for patients. We found that the practice was achieving the required targets across the areas required of them including diabetes medication reviews, child immunisations, hypertension and cervical screening. Their performance was the subject of monthly monitoring to ensure that patients were receiving the best outcomes.

There was a protocol for repeat prescribing which was in line with national guidance. Patients receiving repeat prescriptions had been reviewed by the GP. Medicines were reviewed annually and more frequently when necessary. Repeat prescriptions were not issued until the patient had attended the practice for this review. All new prescriptions were checked and authorised by one of the GPs prior to being given to a patient.

The practice had recently implemented the Gold Standards Framework for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist

Good

Are services effective?

(for example, treatment is effective)

Macmillan nurses. We looked at the minutes of these meetings and found that individual cases were being discussed and care and treatment planned to meets patient's circumstances.

Staff meetings were used to discuss and monitor performance to ensure standards were maintained. Minutes of the meetings reflected that performance of the practice was regularly discussed and all staff were involved with it.

Effective staffing

Although the practice had relatively few members of staff, all had received training to meet the needs of the patients. We viewed training records and found that all staff had received first aid, safeguarding and child protection training. Staff had also been trained in the use of the equipment used at the practice. Training of all staff was regularly reviewed.

We found that staff files contained details of the training they had undertaken and certificates were available for us to view. Records reflected that the practice nurse had received additional training in the specialist areas of child abuse awareness, diabetes, cervical cytology, immunisation and the treatment of anaphylaxis. The practice nurse was supported to undertake their continuous professional development to maintain their skill levels.

The practice was closed for one afternoon every month for training purposes for both clinical and non-clinical staff. Training was planned in advance and records we viewed reflected that this was taking place. Staff we spoke with told us that they found this useful and it provided additional support for them in carrying out their roles.

All staff had received appraisals annually and records held dated back several years. It was clear that the job descriptions of staff were linked to their appraisals and that their performance was being monitored against the objectives of the practice. This included providing high quality care. The appraisals reflected that staff were competent and had been provided with development opportunities, including training needs or career aspirations. Staff were part of a two way process that gave them the opportunity of discussing how they felt working at the practice and what training they needed to do their job effectively. All staff members we spoke with felt supported in the workplace.

Both the GPs were up to date with their yearly continuing professional development requirements and had either 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

Where GP locums were used their qualifications and experience were checked prior to being allowed to work at the practice. This included references and the most recent Disclosure and Barring Service check. Locum GPs were provided with a locum handbook and received an induction process to ensure they understood how the practice operated.

Working with colleagues and other services

The practice held a multidisciplinary meeting every two months. This was attended by other healthcare professionals such as the community matron, social services and district nurses in addition to the practice GPs. These meetings were used to discuss the ongoing care and support needs for patients with long term conditions and those who were elderly. Their care was discussed and planned to ensure they remained healthy and to avoid unplanned admissions to hospital.

We looked at the minutes of these meetings and found that they had a clear agenda with patients being monitored effectively to achieve positive outcomes.

Where patients received care and treatment from other healthcare professionals an effective system was in place to share and receive information about their diagnosis and ongoing care requirements.

The practice updated patient records with information from other healthcare providers in an efficient manner. Where test results, discharge letters, X ray results, out-of-hours consultations and email information were received these were entered on the patients' record on the day they arrived. A member of staff was responsible for this task on a daily basis. We found on the day of our visit that the practice were up to date with this task.

However we did find a different approach in use at the practice in relation to letters received by post and those received electronically. In relation to letters received by post, one of the GPs would review the content of the letter

Good

Are services effective?

(for example, treatment is effective)

to ensure that any changes to care and treatment had been made clear and identified. Where necessary certain patients were followed up and some required to attend for an appointment. The letter would then be passed to a member of the administration staff to add to the record, together with any comments made by the reviewing GP. As far as the electronic letters were concerned, a member of administration staff would check the content of the message and update the patient record then make a decision which ones should be referred to a GP. This meant that the electronic letters were not being reviewed by a GP from a clinical perspective and this leaves room for error.

We discussed this with the practice manager on the day of our visit who confirmed that this was the process in use at the practice. We have asked the practice to ensure that all correspondence is allocated to a GP to ensure they receive some oversight from a clinician rather than by a member of the administration staff, prior to being placed on the patient record. This was agreed by the practice and they are making changes to their procedures.

Patients requiring blood or other clinical tests were seen by the GPs and advised to call and obtain their result. They were given a note to remind them to call the practice and the best time after the consultation. On receipt of a test result it was recorded on the patient's record and the result provided in due course. There was an effective system in place to notify patients who had not called for a result that required a follow-up appointment. Patients were called at home and encouraged to attend. This ensured that patients received an effective service.

Information sharing

The practice used a computerised patient record system known as 'SystmOne' and staff made effective use of it. Consultations, test results and out patient outcomes were saved into the system so all staff could access the latest information about a patient to enable them to meet their needs.

We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. The local GP out-of-hours provider shared patient information in a secure and timely manner and patient records were updated daily. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they can attend to book their outpatient appointments.

Hospital discharge letters that had been received were brought to the attention of one of the GPs, action taken if necessary and the patient's record updated.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They 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 their consent was sought and recorded.

We found that reception staff did not have a clear understanding of Gillick competence. This helps clinicians to identify children aged 16 and under who have the legal capacity to consent to medical examination and treatment without a parent or guardian being present. We discussed this with the practice manager who agreed that more clarity needed to be provided to all staff to ensure they understood the basic principles so that patients of that age could see a GP if they wished, without an adult being present.

Health promotion and prevention

It was practice policy to offer a health check with the 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. In order to make this process streamlined for patients, the practice used the Point Of Care Testing (POCT) method of obtaining blood samples to assess cholesterol or blood/sugar levels, without the need for a patient to attend a hospital. This meant that at a health assessment the patient could receive an immediate indication of some simple steps to take to achieve better health.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75 and these checks were undertaken by the practice nurse. The performance of the practice in this area was the subject of regular monitoring and data reflected that targets were being achieved.

The practice identified patients requiring additional support. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. These patients attended other healthcare professionals for their annual review of their condition and ongoing treatment was followed up by the practice when the relevant information had been received. Care plans in place were the subject of regular reviews.

The practice had also identified the smoking status of their patients and this was also asked of new patients registering with them. They were encouraged to see the practice nurse who had received training to support patients wishing to give up smoking.

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. The practice's performance for cervical smear uptake was currently around 80%. The nurse was responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice was pro-active in identifying patients, through posters in the surgery in different languages, letters to patients and telephone calls. They were aware that the uptake for flu vaccinations was not as high as they would have liked, but had taken action to increase the numbers attending. Travel vaccinations were also available.

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 patient survey and a survey of 90 patients who had completed satisfaction questionnaires in March 2013. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

We also spoke with a number of patients on the day of our inspection and found that they were all generally satisfied with the way the care and treatment wasprovided. They told us that staff were kind and caring and treated them with dignity and respect. There were two male GPs only at the practice and some patients were not aware of the availability of chaperones if they required them although one patient we spoke with had experienced a consultation with a chaperone present and was satisfied with the way it had been carried out. The practice agreed to display a sign in a prominent position so that patients were aware of this facility.

The practice made available to patients, prior to our inspection, CQC comment cards to complete, to tell us what they thought about the practice. Despite the cards being left in a prominent position at reception, we did not receive any replies.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Portable screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff we spoke with were aware of the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff took care when speaking to patients, not to disclose any personal details that could be overheard by others in the waiting room.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with were satisfied about the explanations of their care and treatment and were involved in the planning of it. They said the GP and the nurse explained things in a way they understood and took the time to provide the explanations.

The more vulnerable patients such as the elderly with complex needs, patients with long term conditions and those suffering from dementia were monitored regularly through the use of care plans. Where appropriate, the views of relatives were sought and explanations provided to help them understand the best type of care and treatment that met people's needs.

The patient survey information we reviewed also reflected that 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.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Staff at the practice were pro-active in identifying people with caring responsibilities. Once identified they were offered appropriate support and signposted to external agencies that could help them. Notices in the patient waiting room told carers how they could access a number of different organisations, how to get financial advice and information as to where they could obtain additional equipment and mobility aids if required. A local carers group was also available for them to access.

A system was in place to identify patients who had recently suffered a bereavement. They were offered support by the practice staff and referred to external agencies if required. Literature was available to them in the reception area to identify services that were available to them. The nurse at

Good

Are services caring?

the practice took steps to identify those patients that might be vulnerable after a bereavement and arranged for them to attend the practice to assess their needs and offer advice and support.

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 in the way services were delivered.

We found that the practice understood the needs of the patients using the service and they were tailored to their needs to ensure flexibility, choice and continuity of care.

Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. Patients could request to see a GP of their choice and this was accommodated on most occasions. As there were only male GPs at the practice, patients could use the chaperone service if they wished. On the day of our inspection, there was no chaperone sign available in reception but the practice has agreed to put one on display and promote the availability of chaperones in a clearer way.

Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. Although patient appointments were generally of ten minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues. Patients we spoke with told us that they never felt rushed, that the GPs listened and understood their concerns and gave them the time they needed.

The appointment system was effective for the various population groups that attended the practice. Patients told us that they rarely had to wait until the next day to obtain an appointment and they were very complimentary about the speed at being able to see a GP or the nurse.

As the practice did not have a late evening surgery, patients who worked sometimes found that on some occasions they could not get an appointment at a time that suited them. However the patient survey had not identified this as an issue that needed addressing at this time.

Patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 48 hours but patients we spoke with told us that they were often ready for collection earlier.

The practice did not have a Patient Participation Group but were planning on starting one in the near future.

Tackling inequity and promoting equality

The practice were aware of the different groups of people that made up their practice population and planned its services accordingly.

We found that those people living in vulnerable circumstances such as members of the travelling community of those who were homeless could see a GP at the practice and register as a temporary resident. In some cases they were referred to a nearby walk-in centre for treatment. We were told that the GPs would see anyone from any walk of life based on medical need and not their circumstances.

The premises and services had been adapted to meet the needs of people with disabilities. A parking space for the disabled was available at the rear of the practice and a ramp with a support rail was available for wheelchair users or those with limited mobility, to access the practice. A toilet for the disabled was also available.

The building at the practice was accessible for all patients. 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. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The latter had been implemented as a result of a suggestion in a patient survey.

Access to the service

Appointments were available daily in the morning and afternoons and could be booked with the GP up to six months in advance and with the practice nurse 12 months in advance. Patients could also register to book appointments online. The practice nurse had some morning and afternoon sessions for most of the week as they worked part-time. The practice closed at weekends and did not offer a late evening appointment. One patient who worked during the day commented that this was an issue for them on occasions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice gave priority to patients with emergencies and to children. Some appointment times were blocked off for this purpose. They were seen on the same day wherever possible. We spoke with one patient on the day who told us that they had regularly been able to get appointments for their children when required.

Patients could select their GP of choice if they were available. There were no female GPs working at the practice but chaperones were readily available for patients to use on request.

The practice did not run separate clinics for people with long term conditions as they found that they could meet patient needs with an appointment system. This also gave patients greater flexibility to choose a day when they could come rather than having to attend on a particular day when a clinic was running. The types of conditions that the nurse managed included diabetes, chronic obstructive pulmonary disorder, asthma and various screening services. The nurse was also qualified to provide smoking cessation advice.

Signs were available in the reception and waiting room area that explained the appointment system. It also explained how to obtain emergency out of hour's advice through the 111 system.

Patients were usually allocated 10 minute appointment times with the GPs and the nurse. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a double appointment where necessary to ensure all healthcare needs could be adequately discussed.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system.

The patient survey information and comments from patients that we saw on the day of our inspection reflected that patients were generally satisfied with the appointments system, although some had experienced delays. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. On the day of our visit we observed a patient requesting an appointment for an urgent matter and they were allocated one.

The practice were aware that some feedback had been given in the surveys, that patients were kept waiting too long on some occasions, to see the GP. We were satisfied that the practice were doing all they could to see patients on time, but that factors, on occasions, meant this was not achievable all the time. They had taken steps to bring this to the attention of GPs and to patients who did not attend for their appointments. They had also recently introduced a text message reminder system for appointments.

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.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

Patients we spoke with had not had any cause for complaint. There had been no complaints recorded in the last 12 months.

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. They had an up to date statement of purpose that clearly described their objectives, vision and strategy. Staff spoken with were aware of the direction of the practice and were working towards it.

Staff job descriptions and appraisals supported the direction in which the practice wished to head and they were clearly linked to the vison and objectives. Staff felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available for staff to read. We viewed several of these policies and found that they had been reviewed and read by staff. Policies included information governance, infection control, chaperones and safeguarding.

There was a clear leadership structure with a practice manager and an assistant practice manager. Designated leads included infection control, safeguarding, complaint handling and health and safety. Staff we spoke with were aware of the various leads and knew who to discuss issues with if the need arose.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was reviewed each month to ensure that health targets were being achieved. This was discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice undertook a range of audits that monitored the quality of the services they provided. These included infection control and prescribing medicines. One such audit covered monitoring nutritional food supplements for the elderly and for children. This involved input and advice from a specialist dietician and the subsequent monitoring of the effectiveness of the supplements to improve outcomes for patients.

The practice also undertook a monthly audit on patients that did not attend for their appointments. Where patients had not attended twice in the same period they were corresponded with so that the impact of their non-attendance could be made clear to them. The details of the audit were displayed in the reception area together with a sign that encouraged patients not to miss appointments. The practice had also just begun to send reminders to patients via a text message to their mobile phones.

An external auditing company, commissioned by NHS England, attended the practice in April 2014 to audit the quality of the practice use of QOF. We viewed the report on the day of our inspection and found that very complimentary remarks had been made about the practice. This covered the accuracy of the recording, the organisation skills of the practice manager and the efficiency in the way that the QOF was used.

The practice had robust arrangements for identifying, recording and managing health and safety risks. These were clearly identified and reviewed on a regular basis to ensure that patients and staff were safe.

Team meetings were used to discuss issues and improve practises.

Leadership, openness and transparency

There was strong leadership at the practice. We found that the practice manager led by example and demonstrated to us that they were aware of all policies and procedures and was driving improvement.

We saw from minutes that team meetings were held monthly. Where staff were absent for any reason they were provided with minutes of the meetings to enable them to remain up to date. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. There was a willingness to improve and learn across all the staff we spoke with. The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was very low turnover of staff.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place that included example disciplinary procedures, induction policy and job descriptions which were in place

Are services well-led?

Good

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

to support staff. A staff handbook was available to all staff, which included useful sections to support staff in understanding the procedures to follow and the standards expected of them.

Seeking and acting on feedback from patients, public and staff

The practice showed to us a number of positive comments received from patients who had sent in letters and thankyou cards. There were many in number and they expressed a high level of satisfaction in relation to the services provided.

The practice carried out an annual survey to seek feedback from patients. Records we viewed dated back to 2006. The results of each survey had been analysed to identify areas for improvement and these had been actioned wherever possible. The results of the latest survey were displayed in the waiting room for patients to view. Patients were satisfied with the services provided. One area for improvement was the time kept waiting to see the GP. This was acknowledged by the practice and discussed at staff meetings where it was an agenda item. Action had been taken to help improve in this area including discussions with the GPs so they were aware of the issue. A survey for 2014 is due to take place later this year.

The practice gathered feedback from staff through team meetings and the appraisal process. Staff we spoke with told us that they were encouraged to provide feedback and to contribute ideas for improvement. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice did not have a whistleblowing policy and staff were unclear about the procedures, the protection it offered them and who to contact if there were any concerns or issues. We discussed this with the practice manager who has agreed to implement a policy and provide awareness training for staff.

Management lead through learning and improvement

We viewed records that effective appraisal processes were in place that had been maintained over a number of years. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff files reflected that training had been identified and provided to staff to enable them to meet the needs of the patients.

Audits, the results of a patient survey and the analysis of significant events were used to improve the quality of services. Where audits had taken place these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.