Sandy Lane Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 8

Areas for improvement 8

Detailed findings from this inspection

Our inspection team 9

Background to Sandy Lane Surgery 9

Why we carried out this inspection 9

How we carried out this inspection 9

Detailed findings 11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sandy Lane Surgery on 23 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including those with dementia).

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us that the continuity of GPs was a good feature of the practice, although some told us that appointment times could overrun.
- Risks to patients were assessed and well managed, with the exception of those relating to the practice building.

There were some areas of practice where the provider should make improvements:

- Consider formalising working arrangements with relevant professionals to discuss issues related to safeguarding children and young people.
- Review the availability of suitably trained and vetted staff to provide chaperone duties to ensure a chaperone is available at all times.

Summary of findings

- Improve record keeping of risk assessments and the actions taken in response to identified risks, to promote good governance.
- Review the emergency medicines for the treatment of seizures to ensure that they are age appropriate.
- Consider increased promotion of measures available to improve the health and wellbeing of patients. For example, the provision of flu vaccines in the 'at risk' groups and nationally available cancer screening programmes.

Investigate and implement measures to improve the time keeping of appointments.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Risks to patients were discussed at team meetings and when necessary changes had been made to limit the risk. We saw that risks to patients, staff and visitors from the premises or environmental events were not always clearly recorded, although the practice had taken the appropriate steps to improve safety. Practice staff had been trained to deal with emergency events and equipment and medication to help in an emergency was regularly checked and suitable for use.

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 National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

Patients said that there was good continuity of care with urgent appointments available the same day. Some of the patients we spoke with felt that appointment times could overrun and that they

Summary of findings

were kept waiting, this aligned with the results of the GP national patient survey which showed 41% of patients felt that they do not have to wait too long to be seen. The results were lower than the CCG average of 60% and national average of 66%. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify most risks. The practice proactively sought feedback from staff and patients. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice nurses had a lead role in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There was a non-formal system in place to identify and follow up children living in disadvantaged circumstances and who were at risk. A GP had extended training in women's health. Immunisation rates were in line or higher than the local average for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 held a register of patients living in vulnerable circumstances including those with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours.

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). Seventy-five per cent of patients on the practice register dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and had employed an in house counsellor to provide support to patients. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection. The majority were highly positive about practice staff and described them as approachable, caring and compassionate. The patients told us staff were good at listening, explaining medicines and tests and they all felt very much involved in their care. The patients gave us positive examples of the care and support provided at the practice. We did speak to one patient who told us that they felt a GP had been rude to them on occasion. They told us that they did not make a complaint, although felt enabled to make a complaint if they had wanted to.

We collected 40 cards from a Care Quality Commission (CQC) comments box left in the practice waiting room for two weeks before our visit. Most of the cards contained positive comments and made reference to care of a very good or excellent nature. We saw that the word helpful was used in 11 individual cards. Two comment cards contained comments that were less positive, although there were no common themes to these.

We reviewed the results from the latest GP national patient survey published in January 2015. This survey was based on a return rate of 120 surveys from 330 that were sent out at random to patients registered at the practice. The results from this survey were broadly in line with local and national averages. We saw that two areas were lower than the national average. These were both in relation to interactions with GPs. For example, 64% of patients surveyed felt the GP was good and treated them with care and concern; this was lower than the clinical commissioning group (CCG) of 73% and national average of 75%. We also saw that 73% of patients felt the GP was good at treating them with care and concern; this was lower than the CCG average of 81% and national average of 83%.

There were areas in the GP national survey that the practice scored higher than the local average. For example, the area related to the GP giving patients enough time and explaining test and treatment results.

The survey data also showed that patients rated the care given by the practice nurse highly. For example, 89% had confidence in the nurse.

The results of the GP national patient survey in relation to contacting the practice by telephone and waiting times to be seen were less positive. For example, 41% of patients feel that they do not have to wait too long to be seen. This was lower than the CCG average of 60% and national average of 66%. The practice had higher than average satisfaction rates in the areas of continuity, convenience of appointments and opening hours.

The comments from the comments cards and patients we saw gave mixed views on appointments. Out of the 13 patients we spoke with three said it was difficult to book an appointment, four said it was easy and five patients told us that their allocated appointment time often overran and they had to wait to be seen.

Areas for improvement

Action the service SHOULD take to improve

- Consider formalising working arrangements with relevant professionals to discuss issues related to safeguarding children and young people.
- Review the availability of suitably trained and vetted staff to provide chaperone duties to ensure a chaperone is available at all times.
- Improve record keeping of risk assessments and the actions taken in response to identified risks, to promote good governance.
- Review the emergency medicines for the treatment of seizures to ensure that they are age appropriate.
- Consider increased promotion of measures available to improve the health and wellbeing of patients. For example, the provision of flu vaccines in the 'at risk' groups and nationally available cancer screening programmes.
- Investigate and implement measures to improve the time keeping of appointments.

Sandy Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Sandy Lane Surgery

Sandy Lane Surgery is a GP practice in Mansfield, Nottinghamshire. The historical roots of the practice date back to at least 1930. The practice provides services to patients of all age groups from leased premises.

Data published in 2014 from Public Health England detailed that deprivation is 62% higher in the practice area than the national average. Rates of long-term conditions, smoking and substance misuse are higher than the national average. These factors can increase the demand on GP practices.

The practice staffing consists of four GPs (three male, one female) who provide a whole time equivalent staffing cover of 2.8 GPs. Three female practice nurses have an active role in providing care and treatment to patients. The practice manager leads a team of eight administrative and reception staff. A counsellor, to provide onsite support for patients experiencing poor mental health is directly employed by the practice for three sessions on a weekly basis.

There are currently around 6,000 patients registered at the practice. The practice holds a Personal Medical Services contract with NHS England. It has extended its contractual obligations to provide a number of enhanced services which include extended hours, annual health checks for patients with learning disabilities, minor surgery and avoiding unplanned admissions.

The practice is open between 8am and 6:30pm Monday to Friday. Extended hours surgeries are offered on one Saturday each month from 8:30am to 12pm.

The practice has opted out of providing services to patients out of normal working hours. These services are provided by Central Nottinghamshire Clinical Services Ltd, patients are directed to call 111 to access this service.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS Mansfield and Ashfield Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 23 March 2015.

During our visit we spoke with a range of staff including three GPs, a practice manager, three practice nurses, a student nurse and two members of administration staff. We also spoke with 13 patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We received 40 Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. A GP told us the practice team had discussed significant events at practice meetings for a number of years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these.

Serious events were raised by completion of a standard form available on practice computers which was completed and submitted to the practice manager. The practice had recorded eight significant events in the last year. We tracked three incidents and saw that investigation, discussion and action had taken place in a comprehensive and timely manner in all of them. We saw that learning had been shared following two significant events which related to incorrectly booking patients into appointments. The incidents were investigated and the cause in both cases was patients with similar details wrongly incorrectly selected and booked into the appointment on the computer system. All staff had been given guidance on confirming patients' details and alerts had been placed on relevant patients' records to identify patients with similar sounding names.

A GP told us that significant events were discussed at practice meetings held to help to promote learning. Significant event discussions at meetings had taken place on three occasions during 2014/15. The individual records of significant events detailed a comprehensive account of the issues investigated and discussed.

National patient safety alerts were shared by the GP who received them. Staff we spoke with were able to give examples of recent alerts. They also confirmed alerts were discussed within the practice to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding to an appropriate level. For example, the GPs had received training to level three as suggested in guidance by the Royal College of Paediatrics and Child Health on safeguarding children and young people (March 2014).

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

The practice had an appointed lead GP for safeguarding and the staff we spoke with knew who the safeguarding lead was and how to raise concern. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged. The practice did not meet on a regular basis with local health visitors or others involved in the care of children and young people who may be classified at increased risk of harm. For example, children subject to child protection plans. The practice had over twenty children recorded as being subject to child protection plans.

The practice had a policy on providing chaperones and displayed the availability of chaperones on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All practice nurses had been trained to be a chaperone as part of their professional training and knew their responsibilities when performing the task. We saw that due to the hours of availability when nurses were on duty, there may be times when a trained chaperone would

not be available. The practice manager told us that they were looking into correcting this and the practice was planning to provide reception staff with chaperone training and the character background checks required to enable them to perform the role in a safe and effective manner.

All clinical and nursing staff at the practice had received appropriate checks with the Disclosure and Barring Service (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice planned to perform DBS checks on all reception and administrative staff to enable them to undertake chaperone duties if required.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures which described the action to take in the event of a potential failure. We saw records to confirm staff members undertook daily checks of the medicines.

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

A practice nurse was an independent prescriber. They had undertaken appropriate training and demonstrated they had the skills and knowledge to perform the extended role. The other practice nurses administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that they had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept secure at all times and were handled in accordance with national guidance.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control and had received updates specific to their role. We reviewed records of the most recent practice audit which had been performed in March 2014. As a result of this audit, the practice had ordered additional hand decontamination solution units to be placed outside each clinical room

The practice had a number of policies to promote cleanliness and control infection. These included infection control and specimen handling. There were procedure documents and flowcharts to support these policies to enable staff to plan and implement measures to control infection. For example, we saw that clinical waste was separated from domestic waste. Staff were able to describe items that would be classified as clinical waste and how to dispose of them in a correct manner. There was a policy and procedure in case a member of staff suffered a needle stick injury.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

There was a good supply of personal protective equipment in the form of disposable gloves, aprons, eye protection and covers in clinical areas for staff to use to minimise the risk of the spread of infection.

The practice had completed a risk assessment for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). Two members of practice staff had undertaken training to enable them to check the temperature of water outlets in the practice as part of the risk assessment. We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Good

Are services safe?

Equipment

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

All portable electrical equipment was routinely tested and displayed stickers indicating the date of the last test. We saw that equipment used in the assessment of a patient's condition had been checked and calibrated where necessary to ensure it gave accurate readings. For example, a blood pressure measuring device.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment. For example proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS) where required..

The practice manager told us about arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. This was based on experience of increasing the number of staff on duty when the practice was busy. For example, an additional member of administrative staff was on duty at practice opening times as the practice was at its busiest then.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice manager told us that they undertook regular checks of the building and discussed risks with staff proactively and at staff meetings. We saw that the practice did not record the activities associated with risks. For example, monthly premises checks were not documented.

We saw minutes of practice meetings that showed that issues that may affect safety had been discussed. For example, a central heating leak was discussed and changes to the premises and maintenance was explored.

The staff we spoke with were able to describe the actions they would take if they were faced with an emergency situation, for example a patient whose health deteriorated suddenly. Practice staff gave us examples of situations they had appropriately dealt with.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support.

Emergency equipment was available at a secure central point. Equipment included a nebuliser (a device to help to deliver medicine into the lungs to assist someone with difficulty in breathing), a pulse oximeter (to measure the level of oxygen in a patient's bloodstream) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm).

Emergency medicines were available in a lockable carry box within a secure central area of the practice. A range of medicines were available to deal with medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a patient suffers a seizure/fit) and hypoglycaemia (a very low blood sugar level). We saw that the medicine to treat seizures was in a strength that made it suitable for administration to anyone over the age of six years of age. A patient younger than this would not be able to receive the medicine if it was needed as it would be too strong. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

Guidelines were discussed within protected learning time, in peer discussion and at practice meetings when appropriate.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice delivered a range of enhanced services (ES) to provide patients with additional care and treatment at the practice. ES are the provision of services beyond the contractual requirement of the practice. An example was the avoiding unplanned admission (AUA) enhanced service. The practice had identified 2% of patients who were at high risk of emergency admission to hospital. This included patients who were older, had long-term conditions, dementia and other health conditions. Patients on the AUA register had individualised care plans which were regularly reviewed and changed to meet patients' care and treatment needs. In the event that a patient on the AUA was admitted to hospital, on discharge a GP would contact them to review their care needs. The practice team met on a six weekly basis to discuss patients on the admission avoidance plan. Other ES offered at the practice included minor surgery, and extended opening hours.

The number of patients who had a recorded diagnosis of dementia was previously lower than it was expected to be. Practice staff had responded by checking records and following up patient referrals. GPs used a recognised method of testing for cognition impairment in patients. Cognition relates to attention, memory, judgment and reasoning. Cognitive impairment can be a sign of dementia; patients with impaired cognition were referred to a special hospital clinic for diagnosis. The steps taken by practice staff improved the overall numbers of patients with a recorded dementia diagnosis.

We looked at the latest available data from NHS Business Authority (NHSBA) published in December 2014 on the practice levels for prescribing antibiotic and hypnotic medicines. We saw that the practice levels of prescribing of antibiotics were in the similar to expected range when compare to the national average

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

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The audit was undertaken to establish if patients who experienced poor mental health and took a medicine to help control symptoms, were receiving the correct blood test monitoring in line with NICE guidance. The first audit revealed the blood tests, although taken, were not frequent enough for all of the patients. The results of the audit were discussed and action taken to improve the situation. This included ensuring alerts were placed on patients' notes, also patients were educated on the importance on regular monitoring and the treating clinician was made personally

Good

Are services effective?

(for example, treatment is effective)

responsible for scheduling and following up on tests. The audit was repeated six months later and found that the practice had provided care as detailed in the NICE guidance to all patients.

Other audits included ensuring patients who had been diagnosed with cancer had been appropriately and promptly referred based on their symptoms. Also a further audit explored that treatment for patients who experienced indigestion was in line with best practice guidance.

We saw that staff discussed the practice performance in the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had reviewed performance data that showed that 56% of patients with diabetes had received a blood test result that showed their long-term blood sugar control was within the highest acceptable limit. The national average in this area was 78%. The practice team had discussed the issue at a practice meeting and action agreed to make a GP responsible for reviewing patients.

The practice had achieved 85.6% of the total QOF points available to them in 2013/14; this was lower than the national average of 94.2%. The practice manager told us that they expected the 2014/15 results to be higher than the previous year's performance. We also saw examples of practice performance that was in-line or higher than the national average. For example:

- 90% of patients with dementia had been reviewed in the last year. This was higher than the national average of 84%.
- 82% of patients with hypertension (high blood pressure) had a recent recorded blood pressure reading lower than the highest acceptable limit. The national average was 84%.
- 86% of patients with chronic obstructive pulmonary disease (COPD) had been reviewed in the last year. This was higher than the CCG average of 78% and national average of 80%.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

GPs told us they used nationally recognised methods of the fast track referral to hospital specialists for patients who had symptoms that could be suggestive of cancer. We reviewed data from Public Health England from 2014 which showed the rates for using nationally accepted standards for patients with symptoms that could be suggestive of cancer were in line with both the local and national average.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a wide range of experience and good skill mix amongst the GPs with three out of four holding additional diplomas in medically related areas. One example was women's health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a practice nurse was completing a degree in practice nursing and confirmed that they had received support from the practice to undertake and complete this qualification.

The practice was a teaching practice for medical students training to become doctors. Students in years one and two of their doctor training were supported within the practice. Nursing students were also provided with the opportunity

to learn and develop. We received positive feedback from the second year student nurse we spoke with, they told us they had been supported, given constructive feedback and encouragement.

The practice nursing team consisted of three qualified nurses. They all had an active role in providing care and treatment to patients. All were able to describe their roles and responsibilities and demonstrate how their experience and training met the needs of patients. For example, the lead nurse had completed further training in diabetic care, asthma and chronic obstructive pulmonary disease (COPD) management and held a specialist practice nurse degree. COPD is a term for a number of diseases which affect the function of a person's breathing We spoke with all of the nurses, they were able to demonstrate and describe the impact they had in improving patient care. For example, following a suggestion by one of the nurses, the nursing team met on a monthly basis to discuss patients who had complex problems. A nurse described the meetings as an opportunity to share ideas and make suggestions. They showed us an example of a patient attending for redressing of a pressure area. Treatment options were discussed, ideas of different treatment and referral options were shared and documented in a communication book.

Working with colleagues and other services

The practice had an established system in place for handling and taking action on the information received from local hospitals, out-of-hours providers and the 111 service. The information received was both in an electronic and paper format. Communications included blood test results, hospital discharge summaries and letters from other health partners about the care and treatment of patients. We spoke with staff who were able to describe and demonstrate the system in place for managing communications. The system involved tasking of actions to individual members of staff and where appropriate patients were contacted with an appointment date to discuss results with a GP. The staff we spoke with felt the system worked well. We checked and saw that the management of communications was up to date. There had been no recorded incidents during the previous year where any communication item had not been followed up.

The practice was part of a federated group of practices who met with the CCG on a monthly basis to discuss a range of topics. We saw minutes that showed the practice had measured the number of patient accident and emergency attendances and compared prescribing data with other practices within the CCG.

The number of patients from the practice who attended hospital accident and emergency (A&E) departments was 12.5% higher than the local average. A GP told us they had done an audit of patient attendances and found patients were using A&E appropriately. The attendance rates of patients using a local walk centre to access care were also 30% above the local average. The practice manager told us that they were aware of the data findings although did not fully understand the reasons for the higher than average attendance rates.

The practice rates of referral to outpatient clinics were significantly lower than the local average. Data made available by the CCG showed that the practice had the lowest rate of referral to outpatient clinic within 32 practices in the whole CCG area.

Meetings to discuss the needs of patients who were approaching the end of their life were held on a bi-monthly basis. The meetings were attended by specialist palliative care nurses, community nurses, GPs, practice nurses and others relevant to meeting the care needs of patients. We reviewed minutes of meetings that showed clear actions and interventions had been taken in response to the sharing of information.

Information sharing

The computer system in place at the practice was also used by the out-of-hours provider and community nursing service. The practice manager told us that subject to a patient's agreement information was routinely shared between providers and could be accessed for use in making decisions regarding the care and treatment of patients. Patients who were included in the enhanced service for avoiding unplanned admission to hospital had documented care plans at home and also scanned onto their computerised medical records. The practice manager told us this would help to provide other health professionals with information should they become involved in the patients' care at a time when the practice was closed.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

Good

Are services effective?

(for example, treatment is effective)

care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in decisions about the care they received. An example of this was that 90% of patients on the practice register for dementia had received an annual health check. A GP was able to describe an example of when a patient's capacity had been reassessed and their care plan adjusted to suit their changing needs.

A GP told us that patients and those close to them were supported through decisions when their capacity may be impaired. For example, patients approaching the end of their life received guidance on recording their treatment wishes in the event of their health deteriorating. This information was recorded in patient notes and templates to nationally recognised standards.

Patients' consent to minor surgical procedures was recorded on a standard template. The template was a written record of the benefits, risks, complications and patient's agreement to receive the procedure. The completed consent template was scanned into patients' notes.

Health promotion and prevention

The practice offered a range of in house health promotion services in conjunction with the CCG. These included smoking cessation, weight management and childhood immunisations.

We saw that the most recent published data from QOF showed that vaccination rates for standard childhood immunisations were mostly in line or higher than the local average. For example, 98.7% children aged one had received the pneumococcal vaccine (PCV) to help reduce the risk of acquiring the bacteria that can cause pneumonia, blood poisoning and meningitis. This was higher than the CCG average of 96.6%.

The practice provided NHS health checks for patients aged 40 to 74 years of age. The checks were provided to detect emerging health concerns such as high blood pressure and diabetes. The practice was 10% ahead of a target to provide a certain number of health checks within 2014/15.

The practice rate for cervical cytology screening for female patients aged 25 to 64 years at the practice was 79%, this was slightly lower than the CCG average of 81%. A practice nurse showed us the system of following up patients who did not attend screening appointments, which involved multiple reminders.

Flu vaccination rates for patients aged 65 and over were 75.7%, this was higher than the CCG average of 74.4%. We saw that 46.2% of patients under the age of 65 and in the 'at risk' groups had received a flu vaccination; this was lower than the CCG average of 49.7%. The target in both groups was 75%.

National data from the published by Public Health England in 2014 showed the rates of practice patients attending, or participating in, screening to detect signs that may be suggestive of cancer were mainly slightly lower than CCG average. For example, 54.4% of patients in the age range of 60 to 69 had participated in bowel screening in the last 30 months. This was slightly lower than the CCG average of 59.5% and national average of 58.3%.

It was practice policy to offer all new patients a health check with a GP when joining the practice. The practice waiting room contained posters and leaflets on health promotion subjects and provided patients with contacts for other organisations that may have been able to support with living a healthier lifestyle.

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 GP national patient survey published in January 2015. The survey was undertaken in January to March 2014 and July to September 2014 and was based on 330 surveys being sent to patients at the practice, of which 120 were returned.

The evidence from the GP national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated broadly in line with others for patients who rated the practice as good or very good. The practice was also average for its satisfaction scores on consultations with GPs and nurses. For example:

- 81.1% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 83.9% and national average of 85.3%.
- 85.3% said the GP gave them enough time compared to the CCG average of 83.9% and national average of 85.3%.
- 90.7% said they had confidence and trust in the last GP they saw compared to the CCG average of 90.8% and national average of 92.2%.

Satisfaction scores in relation to the treatment provided by the practice nurses were also in line with local and national averages.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 40 completed cards. The majority of the cards contained positive comments about the practice and staff. Twenty-one cards contained comments that expressed care was excellent or very good. Nine individual cards used the word 'caring'. We received one comment which was less positive. The person who completed the card felt they had been treated rudely by members of reception staff at times. We also spoke with 13 patients on the day of our inspection. The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We spoke with two patients who both felt they had not been listened to when attending a consultation with a GP.

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

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A system operated to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 88.6% said they found the receptionists at the practice helpful compared to the CCG of 86.7% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded with mixed opinions to questions about their involvement in planning and making decisions about their care and treatment and rated the practice mainly below others in these areas. For example:

- 83.4% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79.2% and national average of 82%.
- 64% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 72.4% and national average of 74.6%.

Twelve out of the 13 patients we spoke with felt involved in decisions relating to their care and treatment. One patient said they had not received enough involvement in decisions about their care and treatment. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients responded positively to questions about involvement in planning and making decisions about their care and treatment and rated the practice in line with others in these areas. For example:

- 67.4% with a preferred GP usually get to see or speak to that GP compared to the CCG average of 48.1% and national average of 53.5%.
- 82.7% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83.2% and national average of 78%.
- 80.8% described their experience at the practice as good compared with the CCG average of 83.4% and national average of 85.2%.

We received numerous positive comments from patients we spoke with and within comment cards about the emotional support provided by staff at the practice. We heard examples of occasions of when patients felt that they had received high levels of support at difficult times.

The practice promoted a local befriending charity service to patients who were aged 65 and over and lived alone. The purpose of the service was to provide likeminded people with friendship opportunities. The practice manager told us that the scheme was a pilot and had recently been set up locally. They hoped it would provide additional support to patients who may be socially isolated.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice offered home visits to those who were housebound or not well enough to attend the practice in person. Double appointments could be booked for those with complex health needs. The practice encouraged patients on their website to book a double appointment if the reason for their appointment was complex.

The NHS England Area Team and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We spoke with the chairperson and secretary of the practice patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. They told us that the PPG played an active part in promoting the practice by producing a quarterly practice newsletter and compiling action plans following patient surveys. The most recent patient survey was undertaken in October 2013. The results from this survey had been mainly positive; however we have not included this information in our report as it was the opinion of patients 17 months before our inspection date therefore could not have been relied on to be the current views of patients. The chairperson told us that the PPG meetings routinely involved a member of practice staff and the PPG members felt supported and valued by the practice team. Complaints and significant events were shared with the PPG members to aid learning.

Tackling inequity and promoting equality

All facilities at the practice were situated on a single level. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance.

The practice manager told us about the assistance they had provided by translating items of communications for patients whose first language was not English. For example, a patient with an eastern European heritage took hospital letters to the practice manager who copied them into a computer software programme to convert the written English into the patients' first language. For patients whose spoken English was not strong, a telephone interpreter could be provided.

The practice was not aware of any patients that had circumstances that could present challenges to meeting the requirements of registering for GP services. For example, a person who was homeless. The practice manager told us that they aimed to be a fully inclusive practice and would assist anyone who required their services.

All of the staff at the practice had completed equality and diversity training. The practice staff we spoke with were all able to demonstrate they recognised the importance of treating all patients, carers and visitors with equality and respect for diversity.

Access to the service

The practice was open from 8am to 6:30pm on Monday to Friday. During these times the reception desk and telephone lines were always staffed. Appointment times varied during different times throughout the day and had reflected the availability of the GPs. Pre-bookable appointments were available on a Saturday morning once a month. Patients could book appointments in person, by telephone and by using an online system for those had registered to access appointments in this way. A member of reception staff told us that appointments were a mixture of book on the day (for urgent health concerns) and pre-bookable (for routine concerns). We saw that there were urgent appointments available on the day of our inspection and also pre-bookable appointments within two working days. The practice operated a telephone triage system, when appointments became limited a GP would call the patient and discuss their care needs.

The GP national patient survey information we reviewed showed a mixed response from patients to questions about access to appointments and mostly rated the practice lower than others in these areas. For example:

- 82.5% were satisfied with the practice's opening hours compared to the CCG average of 76.4% and national average of 75.7%.
- 65.2% described their experience of making an appointment as good compared to the CCG average of 71.7% and national average of 73.8%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 44% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65.4% and national average of 65.2%.
- 41% felt they don't normally have to wait too long to be seen compared with the CCG average of 59.4% and national average of 57.8%.

The majority of patients we spoke with found the appointments system easy to use although some found it difficult to get an appointment or felt that appointment times could overrun. Five out the 13 patients we spoke with told us that the time they were kept waiting past their allocated appointment time was too long. They also told us that some GPs ran later than others; however they were very satisfied with the care and treatment they received once they saw the GP. We spoke with the practice manager and the chairperson of the PPG about appointments. They both told us about steps that had been taken to improve the timeliness of appointments. These included extended consultation times from 10 to 15 minutes to allow more time per patient. We saw examples of GPs accommodating appointments for patients throughout the day. It was clear that all of the practice staff including the nursing team and GPs were working hard to accommodate the needs of patients. We saw that appointment waiting time had not been included on the PPG/practice action plan for 2014/15. The timeliness of appointments had featured in the previous two years and steps had been taken to try and improve timekeeping. This included changing the start time of a GP. It was not clear if this had impacted on waiting times as the internal survey had not be repeated and GP national patient survey results were below the local and national averages.

The practice operated a text reminder system for patients to remind them of an upcoming appointment. Telephone appointments and monthly Saturday appointments were available which benefited patients of a working age.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The practice displayed clear information on how to raise a complaint in the waiting room and in the practice booklet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had received five written complaints in the previous year. We tracked the complaints and saw that all complaints had been responded to in an appropriate timescale. Two of the complaints were ongoing and still under investigation. Those who complained were made aware that they could raise their concerns with the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied following the practice findings after a complaint.

The practice reviewed complaints to detect themes and trends and also shared the findings with all staff and with the PPG. Out of the five complaints we reviewed there were no identifiable themes or trends.

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 did not have a formal written vision and values, although staff told us that they placed the care of patients at the heart of the practice. In its Care Quality Commission (CQC) Statement of Purpose the practice listed eight aims and objectives, all eight specifically focussed at the provision of care, treatment and involvement for patients.

All of the staff we spoke with during our inspection displayed and described personal values in line with the provision of high quality empathetic patient care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to each member of staff in the practice manager's office. We looked at three of these policies and procedures and saw that they had been reviewed annually and were up to date. All of the staff we spoke with knew of the existence of policies and procedures and where to access them.

The practice held meetings every month and governance was discussed at each. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The GPs, nurses and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Staff at the practice were aware of their responsibilities for identifying, recording and managing risks. We saw that risk assessments were not always recorded. For example, the practice manager told us that they checked each area of the building regularly to identify hazards, although this was not recorded. However, we did see other evidence that demonstrated that risk assessment had taken place.

Leadership, openness and transparency

The GPs were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Some of the members of staff we spoke with described the practice team like a family.

Staffing levels were stable and most staff members had been employed at the practice for a number of years. Staff told us that there was an open culture within the practice and that they felt respected, valued and supported.

All of the staff we spoke with knew the leadership structure and the scheme of responsibility for individual duties and tasks.

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

The practice gathered feedback from patients by the use of a number of methods. The NHS friends and family test was introduced into the practice in December 2014. The NHS friends and family test asks patients whether they would recommend NHS services to their friends and family if they needed similar care or treatment. The feedback had been positive each month with results ranging from 76-94% of patients saying they would likely or extremely likely recommend the practice. Feedback had also been gathered in the form of internal surveys carried out by the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. This last survey had been completed in late 2013 and a representative from the PPG told us that they were looking at repeating the survey with fewer questions to try and increase the number of responses they received. We saw examples of changes made in relation to partnership working between the practice and PPG. For example, more on the day appointments were made available following the results of a patient survey which highlighted difficulties for patients booking appointments.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was aware that some patients felt that they waited too long past their appointment time. The practice manager told us that the practice had made numerous adjustments over time to change the way appointments were provided. We saw that the timeliness of appointments had been removed from the PPG action plan, despite the 2015 published GP national patient survey results being lower than local and

Are services well-led?

Good

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

national averages. For example, 44% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65.4% and national average of 65.2%.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

We spoke with staff who told us that they had been provided with support and assistance with undertaking higher level training or qualifications.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan.

The practice was a teaching practice for medical students training to become doctors. Students in years one and two of their doctor training were supported within the practice. Nursing students were also provided with the opportunity to learn and develop. We received positive feedback from the second year student nurse we spoke with, they confirmed that they had been supported and given feedback and encouragement.

Significant event and complaint learning outcomes were shared with staff and the PPG. The practice manager told us this was to promote an open culture in which everyone could contribute to improving the care, treatment and experience of patients.