

New Pond Row Surgery

Quality Report

35 South Street
Lancing
West Sussex
BN15 8AN
Tel: 01903 851073
Website: www.newpondrow.co.uk

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

Ratings

Overall rating for this service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Contents

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 New Pond Row Surgery	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11
Action we have told the provider to take	23

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of New Pond Row Surgery on 7 January 2015. We visited the practice location at 35 South Street, Lancing, West Sussex, BN15 8AN. New Pond Row Surgery also operates a branch surgery at 38 Old Shoreham Road, Lancing, West Sussex, BN15 0QT. We did not visit the branch surgery as part of our inspection.

Overall the practice is rated as good. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement for providing safe 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 people with dementia).

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice

understood the needs of the local population and engaged effectively with other services. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients and staff were assessed and well managed, with the exception of those relating to the control of legionella bacteria.
- 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.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice recognised the needs of its older population and had systems in place to support patients through care plans, hospital avoidance schemes and providing extra support for those patients who were vulnerable.

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

Importantly, the provider must:

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the risk of exposure of staff and patients to legionella bacteria.

In addition the provider should:

- Ensure all investigation records and responses to complaints are stored centrally to provide a clear audit trail of actions taken.
- Continue to review and improve access to the practice by phone.
- Repair the key cupboard within the practice to ensure the security of all areas of the practice.
- Ensure adequate staffing levels at all times, particularly to ensure reception staff are adequately supported.

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?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff had a good understanding of procedures relating to the safeguarding of children and vulnerable adults and staff had received training in adult and child safeguarding at a level appropriate to their role. Risks to patients were assessed and generally very well managed. However, the practice had not assessed the risks associated with potential exposure to legionella bacteria. There were enough staff to keep patients safe, although the practice had recently faced some challenges in maintaining staffing levels. Records of staff recruitment checks undertaken prior to employment were incomplete.

Requires improvement



Are services effective?

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 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.

Good



Are services caring?

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 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. The practice advertised local support groups so that patients could access additional support if required.

Good



Summary of findings

Are services responsive to people's needs?

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 they found it easy to obtain an appointment with their GP, although some patients reported difficulty in accessing the practice by phone. Urgent appointments were available on the same day. The practice provided a GP-led triage system which ensured that patients received a return call from a GP within two hours of contacting the practice to assess their needs. The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients.

Good



Are services well-led?

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 risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

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.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles 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 people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Good



Working age people (including those recently retired and students)

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

Good



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 reflected the needs for this age group.

People whose circumstances may make them vulnerable

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 homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability.

The practice regularly worked with multi-disciplinary teams, such as the proactive care team in the case management of vulnerable people. 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.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had identified a lead GP for the management of patients 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. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 31 comment cards which contained mainly positive comments about the practice. We also spoke with 14 patients on the day of the inspection.

The comments we reviewed were generally positive and described the professional, friendly service received by patients. One of the comment cards described the excellent care received in managing multiple health problems during the last year. Three of the comment cards commented on the difficulties associated with getting through to the practice on the phone. All of the patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported. However, some of those patients told us they experienced delays when attempting to contact the practice by telephone.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The survey showed that 79% of respondents described the overall experience of the practice as good, compared with a national average of 85%. The survey found that 84% of patients said the last GP they saw was good at involving them in decisions about their care, compared with a national average of 82%. Just 54% of patients who responded said they found it easy to get through to the practice on the phone, compared with a national average of 75%.

We viewed the practice patient survey results from 2013/2014. The findings indicated that 92.9% of respondents had confidence in the GP they saw and 91.2% of respondents felt they were treated with care and concern by their GP.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process
- Ensure risk assessment and monitoring processes effectively identify, assess and manage risks relating to the risk of exposure of staff and patients to legionella bacteria.

Action the service **SHOULD** take to improve

- Ensure all investigation records and responses to complaints are stored centrally to provide a clear audit trail of actions taken.
- Continue to review and improve access to the practice by phone.
- Repair the key cupboard within the practice to ensure the security of all areas of the practice.
- Ensure adequate staffing levels at all times, particularly to ensure reception staff are adequately supported.

New Pond Row Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP Specialist Advisor.

Background to New Pond Row Surgery

New Pond Row Surgery provides primary medical services to just over 7,200 registered patients. The practice delivers services to a higher number of patients who are aged 65 years and over, when compared with the local clinical commissioning group (CCG) and England average. Care is provided to patients living in four residential and nursing homes. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is similar to the national average.

Care and treatment is delivered by two GP partners and four salaried GPs. Five of the GPs are female and one is male. The practice employs a team of two practice nurses, a healthcare assistant and two part-time paramedic practitioners. GPs and nurses are supported by the practice manager and a team of reception and administration staff. The practice has not been subject to a previous inspection.

Services are provided from:

35 South Street, Lancing, West Sussex, BN15 8AN. New Pond Row Surgery also operates a branch surgery at 38 Old Shoreham Road, Lancing, West Sussex, BN15 0QT. We did not visit the branch surgery as part of our inspection.

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours 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 was 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.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Coastal West Sussex Clinical Commissioning Group (CCG). We carried out an announced visit on 7 January 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patient interaction and spoke with fourteen patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 31 comment cards completed by patients, who shared their views and experiences of the service in the two weeks prior to our visit.

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?

Detailed findings

- 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)

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

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 to 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. 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 systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events were discussed at monthly meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We reviewed the system used to manage and monitor incidents. We saw records of incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we saw the practice had recently reviewed their arrangements to support patients with a learning disability following the emergency hospital admission of one patient.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings 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 in place to manage and review risks to vulnerable children, young patients and adults. A

designated GP partner was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff could demonstrate they had the necessary knowledge to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible within the practice.

Three members of staff we spoke with described recent incidents in which they had reported safeguarding concerns to the GP and the safeguarding lead. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. All nursing staff, including health care assistants, could be asked to be a chaperone. We were told that some reception and administration staff had also been trained to undertake chaperone duties. These staff had not been subject to a criminal records check via the Disclosure and Barring Service but the practice had undertaken a risk assessment of each role to support this decision.

Are services safe?

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records to confirm this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that nurses had received appropriate training to administer vaccines.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local clinical commissioning group (CCG) and the practice participated in prescribing audits and reviews.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and that 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.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection.

The practice had a lead nurse for infection control who had received training to enable them to provide advice on the practice infection control policy and to carry out staff training. The lead had recently provided an infection control update for staff within the practice.

The practice had carried out a comprehensive audit of all infection control processes in August 2014. We saw that an infection control action plan had been developed as a result of this audit. Many of the required actions identified within the audit had been completed. All completed actions and reviews had been clearly recorded.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

The practice had not assessed the risks associated with potential exposure to legionella bacteria which is found in some water systems. The practice manager told us they were involved in close collaboration with neighbouring practices. This group of practices had considered sharing resources to ensure the management of risks associated with legionella but this had not yet been put in place.

Equipment

Are services safe?

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was recorded. We saw evidence of calibration of relevant equipment which had been carried out in March 2014. For example, digital blood pressure machines and weighing scales.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions. We saw evidence that fire safety equipment, including the fire alarm and fire extinguishers, had been serviced in December 2014.

We noted that the main key cupboard within the practice which was intended to ensure that keys were stored securely was not fit for purpose. The lock on the cupboard was not working effectively and presented a risk that keys could be accessed.

Staffing and recruitment

Records we looked at did not contain all the evidence required to show that appropriate recruitment checks had been undertaken prior to employment. For example, files reviewed did not all contain proof of identification including photographic identification, evidence of professional registration and evidence of professional qualifications achieved.

We were told that some reception and administration staff had been trained to undertake chaperone duties. These staff had not been subject to a criminal records check via the Disclosure and Barring Service but the practice had undertaken a risk assessment of each role to support this decision.

Most 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. However, some staff felt that reception staffing levels were sometimes too low, with occasions when reception staff worked alone at certain times of the day. The practice had recently faced challenges in maintaining staffing levels due to a number of changes in personnel but staff told us this had improved recently.

The practice had very recently employed two paramedic practitioners who worked on a job share basis and provided monitoring services to patients. The lead GP told us that the paramedic practitioners were closely supervised by the GP responsible for triage each day.

Monitoring safety and responding to risk

The practice had considered the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed the comprehensive range of risk assessments in place. These included for example, assessment of risks associated with moving and handling, chaperoning, repeat prescribing and health and safety of the environment. All risk assessments had been recently reviewed and updated. However, the practice had not assessed the risks associated with potential exposure to legionella bacteria which is found in some water systems.

The practice had health and safety policies and procedures in place. Health and safety information was displayed for staff to see. Safety equipment such as fire extinguishers and emergency oxygen were checked and sited appropriately.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary. The practice had employed the use of a risk stratification tool to identify patients most in need of high levels of support and who may be at higher risk of frequent accident and emergency attendances and unplanned hospital admissions. The practice held fortnightly meetings with the local Proactive Care Team, which included palliative care nurses, health visitors, the community matron, community psychiatric nurses and district nurses, in order to identify and minimise the risks to these groups of patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated

Are services safe?

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.

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 emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Panic alarms were available to staff in all consulting and treatment rooms in case of an emergency. Records showed that fire alarms were routinely tested. The practice used the services of an external advisor to regularly review fire safety arrangements.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations.

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

The practice had appointed both GP and nurse leads for specialist clinical areas such as diabetes and respiratory conditions. GPs and nurses were well supported in their specialist roles and described a culture of information sharing, transparency and continual learning. For example, the lead nurse for diabetes told us they had undertaken advanced training in diabetes and was a nurse prescriber for diabetes. They met regularly with the lead GP for diabetes to review best practice guidelines and both regularly attended shared care meetings with secondary care services. The practice worked closely in conjunction with the diabetic specialist nurse within the local hospital.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions.

The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice. For example, we saw the practice had recently responded to guidance relating to the prescribing of particular patches to provide pain relief to patients

experiencing chronic pain. The practice had conducted an audit review of the prescribing of the patches in response to the guidance issued. Specific actions taken as a result of the audit findings and learning points identified had been noted. For example, the need to prescribe by brand name and the need to discuss and document clear instructions to the patient about use of the patch.

The practice referred patients appropriately to secondary and other community care services. The GP partners told us that referrals were regularly reviewed in conjunction with the clinical commissioning group.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had systems in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

For example, we saw an audit review of the prescribing of certain antibiotic medicines in response to antibiotic prescribing guidelines. Learning points from the audit had been clearly identified and disseminated to all GPs within the practice. Antibiotic prescribing guidelines were available within each consulting room.

The practice achieved 99.76% of the maximum Quality and Outcomes Framework (QOF) results 2012/13. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF data showed the

Are services effective?

(for example, treatment is effective)

practice performed well in comparison to the regional and national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 97.9%, with the national average being 93.5%. The practice was not an outlier for any QOF clinical targets.

The GPs we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. We reviewed the comprehensive system of data management and monitoring of performance outcomes within the practice. Development of an extensive performance management dashboard enabled the practice manager to produce detailed information packs for the GP partners to review at each monthly meeting. This included for example information relating to unplanned admissions rates, secondary referrals, home visits and all QOF data.

Regular clinical and educational meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around education, audit and quality improvement.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory training courses such as fire safety and safeguarding of children and vulnerable adults. A number of reception and administrative staff were required to act as chaperones within the practice and had received appropriate training to support this role.

The practice nurses provided support to a wide range of patients with long term conditions, such as asthma, diabetes and chronic obstructive pulmonary disorder (COPD). They had previously undergone advanced training in the support and management of these conditions and had recently received updated training. The infection control lead nurse had undertaken appropriate training to support this role.

Staff told us they attended regular external training events supported by the local clinical commissioning group and designated time was identified on a monthly basis to support internal training and meetings.

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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this. A practice nurse told us they last participated in an appraisal in December 2014. This had included a review of performance and the setting of objectives and learning needs. We saw evidence which confirmed this.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. For example, the practice demonstrated they had developed effective working relationships with four local residential care homes which provided care for older patients. A named GP provided visits to residents within these homes as requested and to all new residents registering with the practice.

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and action taken by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received.

Referrals were made using the 'Choose and Book' service. We saw evidence of the practice's referral process and its effectiveness. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Multi-disciplinary meetings with the local Proactive Care Team were held every two weeks. An example of the range

Are services effective?

(for example, treatment is effective)

of patients discussed included palliative care patients, children of concern to health visitors, those experiencing poor mental health and 'at risk' patients including patients who had experienced or were at risk of unplanned admission to hospital.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions. We saw that medical reviews for those patients took place at appropriately timed intervals. Patients with long term conditions were encouraged to set goals in order to manage their condition and promote their wellbeing which were reviewed with the practice nurses. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and provided annual checks for these patients. Nurses told us they were able to signpost patients to local health and wellbeing services, for example to support patients in maintaining a healthy weight or reducing their alcohol intake. One nurse told us how they had successfully introduced screening questions to help identify signs of depression in patients with respiratory conditions.

The practice offered a full range of immunisations for children, some simple travel vaccines, flu and shingles vaccinations in line with current national guidance. We reviewed our data and noted that 100% of children aged up to 24 months who attended the practice, had received their mumps, measles and rubella vaccination. Data we reviewed showed that 98% of patients with diabetes had a flu vaccination within the six month period between September and March. This was higher than the national average of 93%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with 14 patients on the day of our inspection. All told us they were generally satisfied with the care provided by the practice and said their dignity and privacy was respected. One of the comment cards described the excellent care received in managing multiple health problems during the last year.

We reviewed GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 79% of patients rated their overall experience of the practice as good. The practice was above average for its satisfaction scores on consultations with doctors, with 88% of practice respondents saying the GP was good at treating them with care and concern. We also noted that 85% of patients had responded that the nurse was good at treating them with care and concern.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The main reception area and waiting room were combined but patients were requested to wait before coming forward to the reception desk. Some telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they

helped to ensure patient confidentiality. This included not having patient information on view, speaking in lowered tones and asking patients if they wished to discuss private matters away from the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 84% of practice respondents said the GP involved them in care decisions and 86% felt the nurse was good at involving them in decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey showed that 88% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 85% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been supported.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice computer system then alerted GPs and nurses if a patient was also a carer. We saw written information was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had recognised the needs of its patients with long term conditions such as diabetes and had participated in the Year of Care initiative to ensure care planning and promote self-management of a patient's condition.

The 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. The practice manager told us that they collaborated closely with neighbouring practices to determine areas where shared services could provide additional support and cost effectiveness.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and through the patient participation group (PPG). For example, the 2013 practice patient survey which was published in February 2014 indicated that patients would like improved telephone access to the practice and a wider range of appointment availability. The practice had increased the number of pre-bookable appointments available to patients and introduced a system of GP-led triage for patients requiring same day advice from their GP. In order to improve telephone access, the practice had for example, improved the advertising of their GP triage system and extended the times of the triage system to encourage patients to call later in the morning if possible and help reduce the high volume of calls received at the very start of the day.

The practice supported patients with complex needs and those who were at risk of unplanned hospital admission. Personalised care plans were produced and were used to support patients to remain healthy and in their own homes. Patients with palliative care needs were supported. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss

patient and their families' care and support needs. The practice had very recently employed two paramedic practitioners who worked on a job share basis and provided monitoring services to patients.

Patients with long term conditions had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and mental health conditions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were very well supported. The practice provided care and support to patients with a learning disability and worked closely with community services to support their needs.

Staff told us that translation services were available for patients who did not have English as a first language.

The practice was situated in purpose built premises on one level. We noted the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients of the practice.

Access to the service

The practice was open from 8.00am until 6.00pm on weekdays. Extended hours were also available on Monday evenings from 6:00pm until 7.30pm and on Tuesday mornings from 7.30am. Patients could call to make appointments from 8.00am. There were no online facilities for patients to book appointments. Appointments could be booked on the day or up to two weeks in advance. A number of urgent appointments were available on the day. The practice provided a system of GP led triage for other patients requesting urgent appointments. The lead GP partner told us that the aim of the practice was to provide a return call to patients within two hours if the patient felt their concern could not wait until the next available appointment. Locum GPs were not involved in providing triage services to patients. The lead GP told us that the triage system also enabled GPs to identify when patients

Are services responsive to people's needs?

(for example, to feedback?)

would benefit from scheduling of tests and monitoring prior to their GP appointment. For example, the GP might organise a blood test or a nurse monitoring appointment prior to the patient booking an appointment with the GP.

Some patients reported difficulty in accessing the practice by phone. Results of a recent GP patient survey showed that 54% of respondents found it easy to get through to the practice by phone. However, the practice manager told us that of 189 responses to the practice's Friends and Family test, only four patients had raised concerns about telephone access to the practice.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments and the number to call outside of practice hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the out of hours' service.

Patients spoken with and comments left on CQC comment cards confirmed that patients were mainly happy with the appointment system. Several patients told us they were happy with the GP led triage system and always received a timely call back from the GP. The results from a recent GP patient survey indicated that 77% of patients were very satisfied or fairly satisfied with the practice's opening hours.

Listening and learning from concerns and complaints

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

Complaints information was made available to patients in the practice and on the practice website. Friends and Family test suggestions boxes were available within the patient waiting area and reception which invited patients to provide feedback on services provided, including complaints. Most patients we spoke with said they had never had cause to complain.

We reviewed the practice complaints log. We found there had been 13 complaints within the last 12 months. Letters of response had been sent to complainants and learning points had been noted. However, it was not always clear what actions had taken place in order to investigate the complaint and how learning points had been reached. We were unable to see evidence of correspondence sent to patients to initially acknowledge receipt of their complaint. We were told that these were stored separately to other complaint correspondence.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity. The practice had within the last year taken over another local single-handed GP practice and ran this as a branch surgery with staff working between the two practices.

We spoke with 13 members of staff and they all knew and understood the vision and values of the practice and were clear about what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards.

We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Monthly management meetings took place within the practice which facilitated communication between the GPs and the practice manager. Significant events and complaints were discussed with the GPs at those meetings and informally in between times. We reviewed the comprehensive system of data management and monitoring of performance outcomes within the practice. Development of an extensive performance management dashboard enabled the manager to produce detailed information packs for the GP partners to review at each monthly meeting. This included for example information relating to unplanned admissions rates, secondary referrals, home visits and the number of patient calls received.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify

where action should be taken. For example, we saw an audit review of the prescribing of certain antibiotic medicines in response to antibiotic prescribing guidelines. Learning points from the audit had been clearly identified and disseminated to all GPs within the practice. Antibiotic prescribing guidelines were available within each consulting room.

The practice had arrangements for identifying, recording and managing risks. We reviewed the comprehensive range of risk assessments in place. These included for example, assessment of risks associated with moving and handling, chaperoning, repeat prescribing and health and safety of the environment. All risk assessments had been recently reviewed and updated. However, the practice had not assessed the risks associated with potential exposure to legionella bacteria which is found in some water systems.

The practice held regular meetings, including monthly GP partner meetings, weekly clinical review meetings with GP's, nurses and healthcare assistants and team meetings which included administration and reception staff. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were weekly and monthly clinical and management meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time and not just at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and whistleblowing policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients via a patient survey which had last been published in February 2014 and via comments and complaints received. The

Are services well-led?

Good 

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

practice had a small patient participation group (PPG) which had been established since 2009 and met regularly. The practice also had a larger Patient Reference Group which did not meet but from whom the practice sought feedback. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

We saw for example, the most recent survey indicated that patients would like improved telephone access to the practice and a wider range of appointment availability. The practice had increased the number of pre-bookable appointments available to patients and introduced a system of GP-led triage for patients requiring same day advice from their GP. In order to improve telephone access, the practice had for example, improved the advertising of their GP triage system and extended the times of the triage system to encourage patients to call later in the morning if possible and help reduce the high volume of calls received at the very start of the day.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff mostly told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning and improvement

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had

occurred and these were made available to us. Significant events were discussed at monthly meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We reviewed the system used to manage and monitor incidents. We saw records of incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we saw the practice had recently reviewed their arrangements to support patients with a learning disability following the emergency hospital admission of one patient.

All of the GPs within the practice had undergone training relevant to their lead roles and areas of special interest such as gynaecology and child safeguarding. All of the GPs had undergone annual appraisal and had been revalidated.

Staff we spoke with told us they had undergone regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this.

We reviewed staff training records and saw staff were up to date with attending mandatory training courses such as the safeguarding of children and vulnerable adults and infection control. The practice nurses had been provided with appropriate and relevant training to fulfil their roles. For example, the practice had appointed a lead nurse for diabetes and a lead nurse for respiratory conditions. Both lead nurses had undertaken appropriate training to fulfil these roles. The nurses attended regular clinical meetings within the practice and had the opportunity to regularly partake in reflection with the GP partners.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to ensure that patients and staff were protected against the risk of, infection from legionella bacteria which is found in some water systems.</p> <p>This was in breach of regulation 12 (1) (a) (b) (c) (2) (a) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>We found that the registered provider did not ensure that information regarding proof of identity including photographic identification, evidence of registration with a professional body and evidence of qualifications and skills, was present in recruitment files. This was in breach of regulation 21 (a) (i) (ii) (b) (c) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19(1)(a) (b) (2)(a) (3) (a) (4) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>