Dr Khine Kyaw

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?	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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Khine Kyaw, known as Cedar Cross Medical Centre on 24 February 2015. Overall the practice is rated as good for effectiveness, caring, responsive and well led. We found it required improvement for aspects of safety.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and considered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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 make a complaint was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should

- Ensure all staff undertake adult safeguarding and Mental Capacity Act 2005 training
- Ensure doctors have available emergency drugs or have in place a risk assessment to support their decision not to have these available for use in a patient's home.

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- Ensure effective arrangements are in place for the recruitment of locum GPs.
- Consider the use of clinical staff meetings to provide support to Clinical Staff and to share experiences such as patient safety incidents with clinical staff to avoid reoccurrence.
- Review the process in place for sharing national patient safety alerts.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example the recruitment process for locum GPs, access to medicines in patient's homes and adult safeguarding training for all staff.

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 and used it routinely. Patient's 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 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.

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 they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy, though not formally documented. There was a clear leadership structure and staff felt supported by management. Regular practice meetings took place though it was felt that a clinically led meeting might improve the supervision opportunities for the practice nurse. 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.

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. All older patients had a named (accountable GP), older patients with chronic, complex medical conditions and social needs have their own community matron assigned to them undertaking home visits as required. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, offering flu vaccination and home visits if needed.

The practice had undertaken searches of this population group, including identifying those patients who lived alone, who had caring responsibilities and who had been seen in the last 12 months. We saw how further reviews took place to identify those patients who had four or more long term conditions, those who attended A&E recently and those who were housebound.

People with long term conditions

Good

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.

Families, children and young people

Good

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 just below the CCG average for most of the 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,

Summary of findings

health visitors and school nurses. The practice undertakes a joint six week child assessment including the administration of childhood vaccines. Patient information sign posted young people to sexual health services in the area.

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 to ensure these were accessible, flexible and offered continuity of care. Early morning and one late evening session was taking place for patient appointments. 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

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 and annual health checks were carried out for this population group. Examples of this include the joint working with the learning disabilities team in the home assessment of patients with learning disabilities. Staff were knowledgeable about how to support patients with alcohol and drug addiction problems sign posting them to support services locally.

The practice regularly worked with multi-disciplinary teams 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.

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). Systems were in place to ensure people experiencing poor mental health had received an annual physical health check. This included identifying those patients on the practice register that may benefit form a dementia needs review. If the assessment highlighted dementia

care needs the patient would be sent on to the Memory Assessment Service for further review and support. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

A number of patient information leaflets and posters were seen in the waiting area, sign posting patients to agencies that could provide support to the patient or their families. The practice housed support services that could be accessed by patients with poor mental health such as weekly counselling services.

Summary of findings

What people who use the service say

We received 32 completed patient CQC comment cards and spoke with six patients who were attending the practice on the day of our inspection. All of the cards stated how respectful and caring staff were. Patients on the day told us repeatedly that staff were helpful and approachable, they had worked at the practice for a long time so patients felt that they knew their families well. Patients told us it was easy to get an appointment and they liked the recent introduction of open access days.

They were very complimentary about the GPs who worked at the practice about how caring they were and how they spent time listening to their concerns and needs.

Patients told us the practice had compassionate staff, particularly when dealing with patients and relatives who had suffered bereavement. They reported helpful and caring GPs, reception and practice staff.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff undertake adult safeguarding and Mental Capacity Act 2005 training
- Ensure doctors have available emergency drugs or have in place a risk assessment to support their decision not to have these available for use in a patient's home.
- Ensure effective arrangements are in place for the recruitment of locum GPs.
- Consider the use of clinical staff meetings to provide the needed support to clinical staff and to share experiences such as patient safety incidents with clinical staff to avoid reoccurrence.
- Review the formal process in place for sharing national patient safety alerts.

Dr Khine Kyaw

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP and a specialist advisor who was a practice manager.

Background to Dr Khine Kyaw

Dr Khine Kyaw known as Cedar Cross Medical Centre is registered with the Care Quality Commission to provide primary medical services. This is a GMS contracted service close to the centre of the town of Prescot. They have a complete primary health team consisting of doctors, practice nurse, practice manager, reception secretarial and administration staff and pharmacy technicians. The practice has a lead GP partner with a total of two GPs working at the practice.

The total practice list size for Dr Khine Kyaw is approximately 2943 patients, there has been a 6% increase to this in the last two years. The practice is part of Knowsley Clinical Commissioning Group (CCG). The practice is situated in an area that has higher than average areas of deprivation.

The practice is open Monday to Friday from 8.00hrs to 18.30hrs with extended hours as part of their PMS contract. Patients can book appointments in person, online or via the phone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of medical services.

From data we reviewed as part of our inspection we saw that the practice outcomes are in line with those of neighbouring practices within the area. The practice keeps up to date registers of those patients with learning disabilities, mental health conditions and those in need of palliative care. Multi-disciplinary team meetings were in place to support these patient groups.

The practice does not provide out of hours services. These are provided by a separate, external provider called St Helens Rota.

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.

How we carried out this inspection

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

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

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

- Older people

Detailed findings

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

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 25 February 2015.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed CQC comment cards left for us on the day of our inspection.

We spoke with the office and senior managers, registered manager, GP partners, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We explored how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Reports from NHS England indicated the practice had a good track record for maintaining patient safety and during our inspection we found good systems to monitor this.

The practice manager and GPs discussed significant events and showed us documentation to confirm that incidents were appropriately reported. We saw how these were discussed at practice and GP partner meetings to ensure patient safety lessons were disseminated to all staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff reported an open and transparent culture when accidents, incidents and complaints occurred. Staff had received guidance about reporting incidents and all staff were engaged with this. There was an accident and incident reporting policy and procedure in place. Staff told us they were confident about reporting incidents and raising concerns and felt they would be dealt with appropriately and professionally.

We talked with staff about incidents that had occurred at the practice. Mostly incidents were reported in detail, transparently and honestly. Staff we spoke with during the day were open about the cases we discussed, they had been reflected upon and appropriate actions and learning had taken place. We noted however that staff did not always share these experiences with the wider team including GP locums. This could be improved to avoid such incidents being repeated. We were not assured that all incidents were formally reported to the local Clinical Commissioning Group (CCG) however and the practice acknowledged this required improvement.

We saw how complaints made were used by the practice to learn and improve patient safety and experience. From the review of complaint investigation information, we saw that the practice had learnt from the patient experience and appropriate actions had been put in place. For example complaints made about the repeat prescription processes in place.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

There was a current local policy for child and adult safeguarding. This referenced the Department of Health's guidance. Staff demonstrated knowledge and understanding of safeguarding. They described what constituted abuse and what they would do if they had concerns. They had undertaken electronic learning regarding safeguarding of children and adults as part of their essential (mandatory) training modules. This training was at different levels appropriate to the various roles of staff. However formal training for the protection of vulnerable adults had not taken place. The practice had a dedicated GP appointed as a lead in safeguarding vulnerable adults and children and this GP had been trained to enable them to fulfil this role. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Patient's 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 scanned copies of communications from hospitals. 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.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant and on-going issues when

patients attended appointments. For example children subject to child protection plans and older vulnerable patients with dementia. This enabled staff to instantly recognise patient's individual needs and circumstances.

Medicines management

The practice had systems in place for the management of medicines. There was a system in place for ensuring a medication review was recorded in all patients' notes for all patients being prescribed four or more repeat medicines. We were told that the number of hours from requesting a prescription to availability for collection by the patient was 48 hours or less (excluding weekends and bank/local holidays). The practice met on a quarterly basis with the local area team's medicines manager and CCG pharmacists to review prescribing trends and medication audits. Notes of these meetings showed how good practice was discussed and action plans were put into place relating to the prescribing of particular medicines. We observed effective prescribing practices in line with published guidance. Information leaflets were available to patients relating to their medicines.

Clear records were kept when any medicines were brought into the practice and administered to patients. Medicine refrigerator temperatures were checked and recorded daily. Fridges were cleaned on a monthly basis or as needed if there was a spillage. The refrigerator was adequately maintained by the manufacturer and staff were aware of the actions to take if the fridge was out of temperature range for the safe storage of medicines.

The practice had the equipment and in-date emergency medicines to treat patients in an emergency situation at the practice. We saw that emergency medicine, including medicines for anaphylactic shock, were stored safely yet were accessible. We observed that there was a system for checking the expiry dates of emergency medicines on a monthly basis or more regularly if used. We reviewed the doctor's bags available to GPs when doing home visits and found they did not routinely carry medicines for use in patients' homes. There was no risk assessment in place to support this decision.

We observed effective prescribing practices in line with published guidance. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

Cleanliness & infection control

The practice nurse was the lead for infection control. They had undertaken basic training in infection control and obtained support and guidance from the local teams as needed. There was a current infection control policy with supporting policies and guidance. The practice had completed an infection control audit in December 2014. They had achieved an overall scoring rate of 98% compliance with the audit tool and actions plans had been put into place to make improvements.

The environment was clean and tidy and equipment was well-maintained with cleaning schedules for each area. We saw appropriate segregated waste disposal for clinical and non-clinical waste. Contracts were in place for waste disposal and clinical waste was stored securely. The practice had a cleaning schedule to ensure that equipment remained clean and hygienic at all times but cleaning staff did not always sign to show their work was completed. Information was provided to us following the inspection to show how the practice cleaner had been provided with additional training to support them in their role.

The practice used single use items for invasive procedures for example, taking blood and cervical smears. Hand wash and alcohol hand sanitizer dispensers were situated in all clinical rooms. A needle stick/inoculation injury flowchart protocol was displayed in all treatment rooms where the risk to staff of acquiring an infection from this type of injury was more prevalent. Sharps containers were stored in each treatment and consultation room. We saw these containers were stored on worktops and benches away from the floor and out of reach of children. We found that legionella testing had been carried out at the practice.

Equipment

The practice had systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment. Suitable equipment which included medical and non-medical equipment, furniture, fixtures and fittings were in place. Staff confirmed they had completed training appropriate to their role in using medical devices. We saw evidence that clinical equipment was regularly maintained and cleaned.

Staffing & Recruitment

The practice had a recruitment policy in place. Appropriate pre-employment checks were undertaken and completed before employment of staff, such as references, medical and fitness checks. Staff were able to describe their

recruitment process and told us that they had submitted all the required information and appropriate disclosures. There was a system in place to record professional registration such as for the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) but no vaccination status for staff. We saw evidence that demonstrated professional registration for clinical staff was up to date and valid. The practice had used the same locum for a long period of time, fitness checks had been undertaken for this person but no system was in place for the recruitment of other locums that might be used by the practice.

The practice team brought to our attention the increase in the patient practice list and the impact this was having on the staffing resources to meet the increased demands. This was significant also because of a recent staff retirement and there was no replacement at the time of our inspection. Incident reports had been completed when administration tasks had not been completed due to the demands on this group, for example a backlog of scanning of patient records had occurred. At this time extra resources had been added to the team to deal with the backlog but the practice manager and the GP partner acknowledged that staffing resources required improving. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of increased demand for services. The practice manager and GPs maintained and reviewed the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative. Regular risk assessments were undertaken such as an annual fire risk assessment and routine risk assessments of the environment.

There was no clear process in place for receiving and acting on national patient safety alerts. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for but we this was shared informally with staff rather than following a formal process to ensure all staff receive the information.

The practice nurse monitored medications to ensure they were always available and in date. Observation of the emergency treatment bag showed appropriate equipment and drugs for emergency use. Staff confirmed they had received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely in the office area.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available within the building including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed equipment was checked regularly. There was an emergency incident procedure in place. Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system.

Emergency medicines were available in a secure area of the practice, they were segregated for easy access and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check 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. Risks identified included power failure, adverse weather, unplanned staff absences and access to the building. The document also contained relevant contact details for staff to refer to.

Requires improvement

Are services safe?

A fire risk assessment had been undertaken that included actions required for maintaining fire safety standards. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken and equipment checks were undertaken.

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 treatment approaches. We found they were up to date with best practice though the GPs did not specifically follow patient treatment pathways. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were shared and discussed with staff, the implications for the practice's performance. Any impact on patients was discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. We spoke with senior staff who confirmed that when new guidance was issued changes were made to the template assessment documents used by nurses for chronic disease management.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. The practice clinicians worked together as a team, however regular clinical meetings involving the practice nurse were not taking place so they missed the opportunity to share best practice and discussions about complex cases. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions.

We saw how the practice had used a risk profiling review to ensure those more vulnerable patients had their needs assessed and a documented care plan was put in place. However they had introduced a new IT system and the profiling of patient groups had been more difficult. Despite this they had identified specific patient groups such as patients with complex or end of life needs. Individual care plans were developed which included community services and they were shared with the patient and their families.

The practice profile issued by the CCG showed data for the practice's performance for antibiotic prescribing, which was comparable to similar practices. We saw how the practice had achieved improvements with their practice budget overspending working closely with the community pharmacist on this. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review.

The practice profile showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of different specialities. We spoke with the GPs about how this was achieved and monitored.

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

Management, monitoring and improving outcomes for people

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, at practice meeting they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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

A small number of clinical audits were carried out. There had been an audit in relation to NICE guidance relating to patients with a medical condition called atrial fibrillation (a heart condition). This was a completed audit and the practice could demonstrate the changes resulting form the audit results. Other audits we saw were linked to medicines management information, 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). Overall improvements were needed to the number of clinical audits completed at the practice each year.

Good

Are services effective?

(for example, treatment is effective)

Staff had systems in place for checking that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. This was monitored by the practice manager and the lead GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This information was used for example to monitor the population group registers such as for patients with learning disabilities, older patients or specific medical conditions such as diabetes. Regular monitoring of the QOF targets enabled the practice to be ensure all needs including annual reviews were taking place for these patients.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register, a staff member had been given recent responsibility to attend and lead meetings to discuss the care and support needs of patients and their families.

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 mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented.

Staff interviews confirmed that the practice was proactive in providing training for relevant courses. Nursing staff we spoke with told us the practice was very supportive when training and updates were needed.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, administration of vaccines, or cervical cytology or assessing patients with long term chronic disease needs.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and information from out of hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in the passing on, reading and actioning of any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. The systems had been improved in recent months due to a number of incidents that had occurred with patient records and letters. All staff we spoke with understood their roles and felt the system in place worked well. The practice had a system in place to ensure all patients discharged from hospital were seen and their conditions reviewed.

The practice worked closely with other health and social care providers in the local area. The GPs and the practice manager attended various meetings with management and clinical staff from practices across the CCG. These meetings were used to share information, good practice and national developments and guidelines for implementation and consideration.

The practice attended various multidisciplinary team meetings at regular intervals to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by community staff such as district nurses, health visitors, social workers and palliative care nurses. This was a new role for one of the staff members and they were being supported in terms of training and development to undertake this.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Information was shared in this way with hospital and other healthcare providers. We saw that all new patients were assessed and patients' records were set up. This routinely included paper and electronic records with assessments, case notes and blood test results. We saw that all letters relating to blood results and patient hospital discharge letters were reviewed on a daily basis by doctors in the practice. When patients moved between teams and services, including at referral stage, this was done in a prompt and timely way.

We found that staff had all the information they needed to deliver effective care and treatment to patients. For emergency patients, patient summary records were in place. This is an electronic record that is stored at a central location. The records can be accessed by other services to ensure patients can receive healthcare faster, for instance in an emergency situation or when the practice is closed.

Consent to care and treatment

Staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and delivery of their duties in line with this. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. However MCA training had not been provided for practice staff. Staff we spoke with gave examples of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for an invasive procedure. The practice nurse had developed a 'best interest' assessment for patients where mental capacity was a concern. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for patient vaccinations, and to record a parent's written consent for treatment of children.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of any health concerns and these were followed-up in a timely manner. The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. The IT system prompted staff when patients required a health check such as a blood pressure check and arrangements were made for this. Patient and population group registers were in place to enable the practice to keep a register of all patients requiring additional support or review, for example patients who had a learning disability or a specific medical condition such as diabetes. Practice records showed that those who needed regular checks and reviews had received them and the IT system monitored the progress staff made in inviting patients for their annual health review. This included sending letters and telephone calls to patients to remind them to attend their appointments.

The practice's performance for cervical smear uptake was lower than the national target at 75.6% and this was not in line with other practices across the CCG. The practice had identified this as an area for improvement within the practice profile agreed with the local CCG. Performance for national bowel screening across the CCG should achieve an uptake rate of 60%, however the practice only achieved 43.2% in 2013/14. The target range for breast screening across the CCG also was set as 70% and the practice achieved 67%. These services fall outside of the services provided by the practice though they are required to promote the programmes in particular when patients are being invited to the service.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was just below the CCG average in most of the areas and we were shown how non-attenders were being followed up by the practice.

Good

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 32 completed cards and they were all positive about how caring the practice staff were and about the service provided. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Most of the patients said they would recommend this practice to others in the area.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (published on the 8 January 2015) The results showed that 95% of patient said the last GP they saw or spoke to was good at treating them with care and concern. They reported that 98% say the last nurse they saw or spoke to was good at listening to them and 97% say the last nurse they saw or spoke to 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. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and PPG suggestions, a system had been introduced 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.

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

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 94% of practice respondents said the GP involved them in care decisions and 97% said the last GP they saw or spoke to was good at explaining tests and treatments.

Patients we spoke with on the day of our inspection told the GP and nurse always involved them in making decisions about their care and treated. They said practice staff were very supportive. Staff always took time when speaking to patients; an example given was when receptions always looked directly at patients when talking to them instead of looking at the patient computer screen. Some patients told us reception staff always greeted them in a friendly and caring many. 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. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received also spoke positively about how they had received good emotional support and care. We saw patient information leaflets and posters sign posting patients and families to support agencies and services.

Good

Are services caring?

Staff told us that if families had suffered 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings and a practice prolife document where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The actions agreed for this practice in the coming year was to improve the uptake of cervical screening.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). Open access for appointments had been introduced as a pilot for three months to try to improve access for patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the practice now opened late night surgeries for those patients who worked during the day.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events. We found that staff were aware of local services (including voluntary organisations) that they could refer patients to. Patient's information sign posted patients and families to welfare and benefits advice organisations.

The premises and services had been adapted to meet the needs of patient with disabilities. The building was a primary resource centre with disabled access across all areas. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had wide corridors easily accessible for patients with wheelchairs.

Access to the service

The national GP patient survey reported that 97% of patients found it easy to get through to this surgery by phone. The results showed that 96% found the receptionists at this surgery helpful, 90% were able to get an appointment to see or speak to someone the last time they tried and 96% said the last appointment they got was convenient. The results show that 70% usually wait 15 minutes or less after their appointment time to be seen and this concurred with the comments made by patients we spoke with during our visit.

Appointments were available from 8am to 6.30pm each week day. They had recently commenced a three month pilot to open the practice to patients without an appointment for two days each week. This was a popular improvement for patients and those we spoke to during the visit told us it was a marked improvement in terms of getting a suitable appointment. The practice's extended opening hours on one day each week was particularly useful to patients with work commitments.

The practice had a comprehensive website which included appointment information. This also included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring.. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients as required.

Patients we spoke with and the practice's patient participation group were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the

Good

Are services responsive to people's needs?

(for example, to feedback?)

doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice had recently completed a patient satisfaction survey and this was undertaken in partnership with the practice's patient participation group (PPG). They received 126 responses from patients and views were sought for areas such as access, the electronic prescribing systems and information governance. From the results the PPG had identified areas where improvements were required, for example patient access and an action plan had been put into place. In an effort to improve patient access they had recently undertaken a pilot to operate two open access appointment sessions a week during which time no appointments would be made and patients could call on the day for their appointment. The pilot was on going at the time of our visit.

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. The practice manager and lead GP reviewed and responded to all complaints made.

We saw that information was available to help patients understand the complaints system in the reception area, this included a patient complaints leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at two complaints received in the last 12 months and found that timely, open and appropriate responses had been made. The practice reviewed complaints annually to detect 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 had an unwritten vision to deliver good patient care and staff were engaged with this. A formal and written patient strategy was not in place. There was a clear leadership structure and staff felt supported by management. We spoke with a number of staff across, they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They shared the same ethos which was to deliver patient centred care in a compassionate and caring way to patients and their families.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of computers within the practice. These policies were linked to the local Clinical Commissioning Group (CCG) website so they were current and up to date.

The practice team were open and transparent during our visit talking us through their achievements and the areas where they needed to make improvements. Staff reported an open culture where they were not anxious about raising concerns with the management team. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior GP was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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 or at times above average with national standards. We saw that QOF data was regularly discussed at practice team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had arrangements for identifying, recording and managing risks. We saw that the risks were regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. An example of this was the infection control risk assessment which had been completed by the practice nurse in December 2014. We found that the more negative results had been acted upon.

The practice did not hold formal clinically led management meetings and the practice nurse did not have protected time with the GP for supervision or to discuss complex issues. The practice recognised that arrangements were informal and required improvement. All practice attended practice meetings every two months, detailed minutes were seen. We looked at the minutes for the December 2014 meeting which showed that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least every two months. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

We spoke with staff with different roles and they were clear about the lines of accountability and leadership. They spoke of good visible leadership and full access to the senior GP and practice manager. Staff told us they enjoyed working at the practice and they felt valued in their roles. Staff felt supported, motivated and reported being treated fairly and compassionately. They reported an open and 'no-blame' culture where they felt safe to report incidents and mistakes. The practice had a strong team who worked together in the best interest of the patient. All staff were aware of the practice Whistleblowing Policy and they were sufficiently confident to use this should the need arise.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. They included sections on equality and harassment and bullying at work. 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 through a patient survey, via comments cards and on line. Over the last 12 months the surgery has had a Friends & Family Test survey on the homepage of their website. Patient

Are services well-led?

Good

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

complaints were also reviewed for feedback. We looked at the results of these and the annual patient survey and saw that action actions had been taken for all of the areas patients reported a less positive experience.

The practice had an active patient participation group (PPG) and during our visit we met with six members. They spoke positively about how supportive the practice staff had been as the group developed and grew in confidence. The practice manager and the GP regularly attend the PPG meetings and take on board the comments its members make. The PPG had been very active in encouraging patients to complete the surveys that they had designed themselves. The results were displayed in the patient waiting area showing the negative and positive comments made by patients.

The practice had gathered feedback from staff on an informal basis and formally during regular staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was an open and no blame culture and staff felt supported to raise concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 five staff files and saw that regular appraisals took place which included a personal development plan.

Staff had access to a programme of induction and training and development. Mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff were supervised until they were able to work independently but written records of this were not kept.

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