Swavesey Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Swavesey Surgery on 29 April 2015 as part of our comprehensive inspection programme. The overall rating for this practice is good.

Specifically, we found the practice to be good for providing a safe, caring, effective, responsive and well led service. It was also good for providing services for older patients, patients with long term conditions, patients in vulnerable circumstances, families, children and young patients, working age patients and patients experiencing poor mental health. 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.
- Arrangements around the security of medicines and prescription pads needed to be improved.
- Staff took account of changes in national guidance when planning patient care.
- Staff had access to training to update their skills.
- Practice staff provided proactive and tailored services to vulnerable patients
- The practice had a robust governance structure in place with a designated quality lead, alongside a range of different regular meetings for staff.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a clear leadership structure and staff felt supported by management.

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

- Carry out a risk assessment on their arrangements for the security of medicines

Actions the provider must take

- Improve the arrangements for the security of blank prescription forms in line with NHS guidance (Reg 12(2)(g)).

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. There were systems and processes in place for managing and responding to safety alerts. Staff learnt from any incidents and events that occurred in the practice and we found changes had been made as a result. Patients, staff and visitors were protected against the risk of health care associated infections. Arrangements were in place to manage emergencies. Staffing levels were appropriately managed and maintained and there were enough staff to keep patients safe. There are improvements required around the security of prescription forms and medicines.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that overall patient outcomes were either in line or above average for the locality. The practice had completed a scheme of clinical audit cycles covering a broad range of clinical areas. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely, to ensure care pathways reflected best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. Arrangements were in place to promote patient health. Staff had received training appropriate to their roles. 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 were very satisfied with the care they received from the practice. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that the practice had taken steps to ensure information was accessible to patients. During our inspection we 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 GP and that there was continuity of care, with urgent appointments available the same day. The practice well equipped to treat patients

Summary of findings

and meet their needs; they made good use of the existing limiting space. The practice provided rooms for other health services to avoid the local population having to travel. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evidenced.

Are services well-led?

Good

The practice is rated as good for well-led. Staff strived to achieve the common goal of good quality care via a shared vision. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient representatives group (PRG) was active. Staff had received inductions, performance reviews and attended staff meetings and events. The practice recently internally promoted a member of staff to a more senior position.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Monthly multi-disciplinary meetings were held to identify the best ways to provide care to palliative care patients and, where appropriate, to avoid them going into hospital. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it.Older people we spoke with told us that they could get an appointment on the same day if they needed it and that they were satisfied with the care provided.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed and nursing staff took special interest in a variety of long term conditions. For those patients with the most complex needs, the practice worked with relevant health and care professionals to support patients. The practice supported patients to manage a range of long term conditions in line with best evidence based practice.

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 who were at risk, for example, vulnerable children and those under the care of the local authority (in foster or other care arrangements). Immunisation rates were generally 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 health visitors, especially around safeguarding elements.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice provided extended hours on Tuesdays. The practice provided the option of online booking for appointments and SMS text confirmations. Health promotion and screening that reflected the needs for this age group was taking place.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had not carried out annual health checks but did offer longer appointments and maintained on-going contact with all registered patients with a learning disability. The practice looked after patients from several fixed traveller sites and had improved the access for these patients through vaccinations and flexibility around prescriptions. 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Clinicians provided empathetic and responsive care to patients with poor mental health. Patients experiencing poor mental health were invited to attend the practice for different physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We received 23 completed comment cards all of which were positive. We spoke with four patients during our inspection, including two members from the patient representatives group (PRG). The PRG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PRGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The patients we spoke with told us that they felt the practice was clean and that they felt that they received a good level of care. All patients we spoke with expressed their opinion that the practice provided a very good personal service and that GPs and nurses delivered good clinical care acknowledging the patients' interests. The comment cards reflected these views, all with very positive comments. All patients confirmed that they could always get an urgent appointment with a doctor within 48 hours. None of the patients we spoke with claimed to have had issues booking routine appointments. We spoke with two representatives of the PRG. We were told that they felt listened to by the practice and that the standard of care they received was of a high quality. They provided evidence that the practice had taken their comments and suggestions on board in the past. They were able to evidence support from the practice with the organisation of patient surveys for the last three years.

Areas for improvement

Action the service MUST take to improve

- Improve the arrangements for the security of blank prescription forms in line with NHS guidance (Reg 12(2)(g)).

Action the service SHOULD take to improve

- Carry out a risk assessment on their arrangements for the security of medicines

Swavesey Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector. The team included a GP specialist advisor and a medicine optimisation inspector.

Background to Swavesey Surgery

Swavesey Surgery in Boxford End, Swavesey provides services to patients living in Swavesey and the surrounding area, including the villages of Over, Willingham, Fen Drayton, Longstanton, Lolworth, Boxworth and Bar Hill. The practice is managed by an individual GP. The registered male GP is supported by three regular female locum GPs and one was on maternity leave at the time of our inspection. The practice also employs three practice nurses, a dispensary manager and a dispenser. The clinical team is supported by a practice manager, a deputy practice manager (who also covers as a dispenser) and a team of three receptionists/administration staff. The practice has a patient population of approximately 2700. GP appointments are available every weekday between 08:00 and 13:00 and then from 14.00 until 17.00. Extended hours are provided on Tuesday mornings from 07:15 until 08:00 and on Tuesday and Wednesday evenings from 17:00 until 18:00, the practice closes at 16:00 on Fridays. The practice website clearly details how patients may obtain services out-of-hours. The practice has a registered pharmacy attached providing dispensing services to patients.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations such as the local clinical commissioning group (CCG) and the NHS England Area Team. The CCG and NHS England are both commissioners of local healthcare services. We carried out an announced inspection on 29 April 2015. During our inspection we spoke with a range of staff: reception, administrative and clinical staff. We also spoke with patients who used the service, and two representatives of the patient representative group (PRG). The PRG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PRGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. We reviewed comment cards which we had left for patients and members of the public to share their views and experiences of the service. We also reviewed a range of different records held by the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients via the suggestion box in the waiting room. The practice had implemented systems for reporting and responding to incidents. We reviewed incident reports and minutes of meetings where these were discussed for the last year. We saw evidence that the practice had managed these consistently and so could demonstrate a safe track record over time.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, two fridges had failed during the last year and the staff had sought advice from pharmaceutical companies on what actions to take regarding the medications kept in the fridges and replaced the fridges.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred and these were made available to us. A practice meeting was held bi-monthly during which significant events were discussed. We saw minutes and evidence that the practice had reviewed actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff.

We reviewed records in respect of each of the significant events identified and recorded in the previous year. The notes included actions that had been taken in response to the incidents to reduce future recurrence and improve patient safety. We found a number of incidents had been reported including issues relating to medicines dispensing, medicine fridge failures and an on-site accident. Staff used incident forms on the practice intranet and sent completed forms to the practice manager for processing. We tracked eight incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example we saw appropriate handling of a dispensing error which resulted in dispensary staff being allocated additional protected time for dispensing activity

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated electronically to practice staff and discussed in person. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. There was no register in place evidencing which alerts had been disseminated to whom but we saw that relevant comments on the alerts had been made via replies to the initial notification. Locum GPs were kept informed via the provision of a locum file.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. The GP 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. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk.

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's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after, or on child protection plans, were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Good

Are services safe?

A chaperone protocol was in place and information was clearly displayed in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Chaperone training had been undertaken by two receptionists who acted as chaperones when nursing staff were unavailable. The protocol in place explained and risk assessed issues around non-clinical staff acting as a chaperone. All staff that provided chaperoning had Disclosure and Barring Service (DBS) checks in place that were up to date. The practice manager informed us that these checks were re-done every 3 years.

Medicines management

We looked at all the areas where medicines were stored and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary was well organised and operated with adequate staffing levels.

A policy and procedure folder was available in the dispensary for staff to refer to standard operating practices. We saw that procedures were updated regularly and records showed that staff had read them.

We checked medicines stored in the treatment rooms and medicine refrigerators. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. However medicines were not all stored securely and we were not assured that they were only accessible to members of staff.The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of the directions and evidence that nurses had received appropriate training to administer vaccines.

Medicines for use in an emergency were monitored for expiry and checked regularly for their availability.

Dispensing staff were aware that all prescriptions must be reviewed and signed by a GP before they were dispensed, and we saw this working in practice.

Blank prescription forms were not handled in accordance with national guidance as these were not tracked through the practice and kept securely at all times. We could not be assured that if prescriptions were lost or stolen this could be promptly identified and investigated.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Dispensary staff recorded errors in the supply of medicines to patients and 'near miss' errors which were reviewed at practice meetings.

National patient safety alerts relating to medicines were received by dispensary staff who were able to give examples of recent alerts that were relevant to the care they were responsible for.

Records showed that all members of staff involved in the dispensing process were qualified and their competence was checked regularly.

The practice provided a delivery service for a limited number of patients and had arrangements in place to ensure these patients were given all the relevant information they required.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to check adequacy of, and compliance with, the practice's infection control policy. The staff received annual training in infection control prevention and its processes. All staff we spoke with were aware of infection control practices.

Auditing of infection control processes was carried out regularly and appropriate action plans had been instigated upon the findings. For example, we saw audits had been completed in April 2015 on cleanliness of practice areas.

Good

Are services safe?

Minutes of practice meetings showed that infection prevention and control was discussed. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection.

Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Spillage kits were available in various rooms in the premises. We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor operations they performed. The practice had a policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in buildings). There were records that confirmed one of the practice nurses had performed quarterly checks with support and advice available from an external company. Checks were documented and being undertaken to reduce the risk of infection to staff and patients.

We saw that the practice had arrangements and notices in place for the segregation of clinical waste at the point of generation. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles. During the inspection we found records of staff immunisation against Hepatitis B. We found that this was monitored to ensure staff were protected.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of interventions, including minor surgery. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date were present. A schedule of testing was in place and this was in date. We saw evidence that calibration of relevant equipment was done and in date. Staff told us that all tests and checks were performed annually by an external company.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were shown evidence of current DBS checks for clinical and non-clinical staff; having this in place is not a requirement unless staff are left alone with patients, which we were informed, unless they acted as chaperone, they were not. We were also informed that renewal of all staff DBS checks was done every three years.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional body. Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was an arrangement in place for members of nursing, dispensing and administrative staff to cover each other's roles. Staff we spoke with confirmed that this happened and these arrangements worked well. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

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 a comprehensive range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety and the workplace environment. All risk assessments had been reviewed and updated; each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at the practice meetings. For example, screws in the children's chairs in the waiting room were found to be loose and were tightened.

We spoke with both clinical and non-clinical staff about managing risks and found that they had the skills to safeguard patient safety. We observed that the practice environment was organised and tidy. Safety equipment such as fire extinguishers and defibrillators were checked

and sited appropriately. There was no sign present indicating the location of the oxygen equipment but all staff were aware of its location. For fire safety it is important to display such a sign. The practice advised us this was addressed immediately after our inspection.

Health and safety information was displayed for staff to see and health and safety policies and protocols were in place. One member of the reception staff was appointed as health and safety representative and fulfilled associated duties. Staff we spoke with provided evidence that they were able to identify and respond to changing risks to patients. This included deteriorating health and well-being with an explanation of how they responded to patients experiencing an emergency medical situation, including supporting them to access emergency care and treatment. One of the nurses specialised in asthma and chronic obstructive pulmonary disease (COPD– severe shortness of breath caused by chronic bronchitis, emphysema, or both) and another in diabetic care; an additional diabetic specialist nurse visited the surgery on a monthly basis providing effective access to treatment for, and the monitoring of, diabetic patients. These patients were reviewed six monthly or annually.

The practice regularly monitored and recalled patients on high risk medicines, this was monitored by the reception team who would keep track of the recall periods.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including a defibrillator and oxygen were available for use in the event of a medical emergency. The equipment was checked regularly to ensure it was in working condition. All staff had received face-to-face training in basic life support to enable them to respond appropriately in an emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was explored and mitigating actions were recorded to reduce and manage the risk. Risks identified included loss of access to the IT server, loss of telephone system, loss of utilities, a gas leak, prevention of entry to the building and staff unavailability. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed and details of all the staff members. Several copies were held off site at locations known to the practice staff. The practice had carried out a fire risk assessment and records showed that all staff were up to date with fire safety training.

Good

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 monthly practice meetings where new guidelines were discussed. 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 GP and nurses that staff completed thorough assessments of patients' needs, in line with NICE guidelines and these were reviewed when appropriate.

The practice employed practice nurses who had a special interest in the on-going care and support for patients with long term conditions such as diabetes and asthma with support from the GPs. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Staff told us this supported all staff to continually review and discuss new best practice guidelines.

The practice had a peer review system with other local practices to enable shared learning and improvement. This was done via regular meetings of which we saw minutes. We were told that all patients received appropriate treatment and regular review of their condition. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with mental health complaints or those with long term conditions. The practice supported patients to manage a range of long term conditions in line with evidenced based best practice. For example, we saw evidence that the practice had implemented changes to prescribing certain licensed medications following licensing issues. The practice had identified affected patients and changed their medication.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which indicated the GP would contact patients on the day when a discharge letter was received and according to need a follow up consultation or home visit would be arranged. Discrimination was avoided when making care and treatment decisions. Interviews with staff 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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management. The practice achieved 93.5% of the maximum 2013/14 Quality and Outcomes Framework (QOF) results in the clinical domain against the local average of 86.6%. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed above average in comparison to the national and local figures. For example, the practice maintains a register of all palliative care patients, irrespective of age where all patients are part of regular (at least 3 monthly) multidisciplinary case review meetings; the practice performed at 100% against a 99.5% local average and 96.7% national average. The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included COPD management and diabetic prescribing. These audits included a two cycle review and appropriate learning outcomes were followed up and changes made.

Bench marking with other local practices was carried out and the outcomes of these provided the basis for further learning within the practice. The practice had regular meetings with other local practices in the locality to discuss patient care and share learning, for example medication prescribing. Staff spoke of a culture of quality improvement and continuous learning within the practice.

The lead GP carried out the minor surgery and had attended appropriate training to do so. The practice kept a log of all minor surgery procedures, including results, complications and referrals where necessary.

Good

Are services effective?

(for example, treatment is effective)

Incoming correspondence regarding patients from other providers (for example hospitals or out of hours services) was reviewed by the GP in the morning (in the case of overnight/weekend correspondence) or on receipt during the day.

Effective staffing

Practice staffing included medical, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training such as annual basic life support and health and safety. We noted a good skill mix among the management team with the practice manager working part time but also working at other local practices, enabling close cooperation and with the deputy practice manager also able to work as a dispenser in the pharmacy.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. All appraisals we viewed were up to date and had a progressive evidence trail of at least three years. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses in addition to the mandatory training, for example records management, conflict resolution, access to health records and foundation in acupuncture. The practice nurses had been provided with appropriate and relevant training to fulfil their roles. For example, immunisation updates and cytology sampling training. The nursing staff were also regularly clinically supervised by an externally contracted clinical supervision nurse. They also held a regular practice nurse forum in protected time and were able to attend lectures at a local hospital.

Reception and administrative staff had undergone training relevant to their role. For example, records evidenced they had received training in the mental capacity act and "prevention is better than cure". Staff described feeling well supported to develop further within their roles. For example, a former dispenser was now working as deputy practice manager.

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, anticipatory care planning for those patients with wishes relating to hospital admission avoidance and palliative care. Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and acted upon by a GP on the day they were received. In the absence of a patient's named GP, the GP on duty within the practice was responsible for ensuring the timely processing of these reports.

The practice held monthly multidisciplinary team meetings, of which we saw minutes, to discuss the needs of complex patients, for example those with palliative care needs or patients recently discharged from hospital. These meetings were attended by community matrons, district nurses, social workers, palliative care nurses and decisions about care planning were documented in notes and action plans. The practice participated in enhanced service from the clinical commissioning group (CCG), Public Health and NHS England (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). For example, the practice had recently signed up to delivering an enhanced service focussing on alcohol dependency with the aim to reduce hospital admissions and initiate detox programmes.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient 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. Care plans were shared with patients to ensure their full involvement in decision making and to facilitate sharing of information with other services, such as out of hours services. The practice used information received to ensure patient care was being planned effectively. For example, the practice received out of hours data upon which it acted to instigate follow ups for treatment. This information was disseminated to the patient's named GP.

Patients were contacted by their GP or the practice nurse on the day of receiving a discharge letter from hospital to

Good

Are services effective?

(for example, treatment is effective)

explore future admission avoidance. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. 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

Patients we spoke with told us that the GPs and nurses always obtained consent before any examination took place. We found that staff were aware of the Mental Capacity Act 2005 (MCA), the Children Acts 1989 and 2004 and their duties in fulfilling it. We saw evidence that all staff had received training in the MCA. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had drawn up a consent protocol to help staff with highlighting how patients should be supported to make their own decisions and how these should be documented in the medical notes. Patients with mental health complaints and those with dementia were supported to make decisions through the use of care plans, which they and / or their carers were involved in agreeing. These care plans were reviewed six monthly or annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). There was an alert flash up system present on the computer system to remind staff of this when seeing a patient under the age of 16.

The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. 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. The practice had not needed to use restraint recently, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

Staff we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We saw that medical reviews for those patients took place at appropriately timed intervals. 2013/14 data showed that 88.9% of people with severe mental health problems registered at the practice had a comprehensive care plan documented. This was above average for the CCG as well as nationally. The practice kept a register of all patients with a learning disability. The number of patients on this register was low and the practice informed us they were aware of each of the patients' individual circumstances, including reasons why they were not able to attend the practice and the care that was in place for them. None of these patients were considered by the practice as "at risk" or in need of a care plan.

There was a variety of information available for health promotion and prevention throughout the practice, in the waiting area and on the practice website. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home. Data showed that 515 vaccinations were provided out of a potential 1382 patients. Others were declined or received a recall. The nurses we spoke with us told us there were a number of services available for health promotion and prevention. These included child immunisation, sexual health education, counselling, diabetes, chronic obstructive pulmonary disease (COPD), asthma, cervical screening, smoking cessation support and travel vaccination appointments. It was practice policy to offer a health check with a practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years, these were performed by the nursing team. The practice manager informed us that a total of 232 out of 519 eligible patients, between April 2014 and April 2015, took up the offer of the health check. Staff told us how patients were followed up, initially by a nurse, if they had risk factors for disease identified at the health check and how they scheduled further investigations.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake in 2013/2014 was 85.5%, which was better than the average in the CCG area or nationally. Patients were invited to attend via letter, with up to three reminders. A nurse would follow up patients who did not attend screening. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Staff told us that the practice holds a register for patients that lived in the travellers' community. There were arrangements to follow up non-attenders as well as provide medication for extended periods, in case of these patients vacating the area for several months on end.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient survey last updated in January 2015, which was completed by 129 respondents, and a survey undertaken by the practice's patient representatives group (PRG) which was returned by approximately 10% of the total patients list, reflecting approximately 270 respondents. The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice was rated lower at 78% than the CCG average of 83% for respondents saying the last GP they saw or spoke to was good at involving them in decisions about their care. However, the PRG patient survey concluded that 100% of respondents had confidence and trust in the doctor/nurse they saw and 99% would recommend the surgery to someone who just moved to the area..

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and all were positive about the service experienced. Patients commented positively around the availability of appointments, the politeness of staff, the cleanliness of the practice, the caring and accommodating nature of the staff and that they were treated with compassion and respect. We spoke with four patients on the day of our inspection including two representatives of the patient representatives group (PRG). All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard. Staff respected patients and preserved their dignity and privacy. Privacy curtains were in place in consultation rooms. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard, this was aided by the playing of the radio in the waiting area and hallway. 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 not located away from the reception desk which did not assist in keeping patient information private. However, due to the small size of the practice there was generally only one member of reception that took phone calls as well as serve the reception desk. There was the option to have private conversation in person or over the phone in a separate room. In response to patient suggestions, SMS text services were made available as a communication means for appointments.

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. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The GP 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 below average in these areas. For example, data from the national patient survey showed 78% (against 83% local average) of practice respondents said the GP involved them in care decisions and 81% (against 88% local average) felt the GP was good at explaining treatment and results. According to the GP patient survey 94% of respondents said the last nurse they saw or spoke to was good at giving them enough time and 95% said the last nurse they saw or spoke to was good at explaining tests and treatments

Patients we spoke with on the day of our inspection told us that their health complaints were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt their children were dealt with in age appropriate way by the practice staff. Patient feedback on the comment cards we received was all positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The practice had a system for ensuring that all staff were kept up to date on the status of palliative care patients. This was to ensure appropriate care was delivered and to reduce the risk of any inappropriate contact by the practice staff following a bereavement, for example issuing a letter in the name of the patient. Patients would be assessed on their severity and depending on this reviewed daily, monthly or weekly. The GPs told us they would contact suddenly bereaved families or would seek contact in end of

Good

Are services caring?

life circumstances to provide care and support to the patients and their families. This 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. Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice offered flu vaccinations to carers.

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. Support was offered to a sheltered housing complex by means of personal medicine delivery and to ensure that the clinical and social needs of the patients that lived there were identified and met. The patient representatives group (PRG) was proactive and had challenged and supported the practice to improve. As a result, SMS text services were made available as a communication means for appointments and the approach to answering the telephone by the call takers was addressed. This improved patients' experiences in reception and booking appointments. PRG members attend quarterly meetings with the practice manager and GP.

The practice told us that they engaged regularly with the NHS England Area Team and Clinical commissioning group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, recent changes in an ophthalmology pathway and an out-of-area patient registration update.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, including patients from local fixed traveller sites. The practice told us that over the years they had built up trust and improved health issues by inclusion of vaccination and healthy lifestyle promotion to their best ability. There were arrangements to follow up non-attenders from this community as well as provide medication for extended periods, in case of these patients vacating the area for several months on end. The practice also kept a register of patients that were carers, had a carer or received carer support; these patients were offered flu vaccinations and supportive information for carers was available in the waiting room.

The practice held monthly multi-disciplinary (MDT) meetings, which were coordinated by regional MDT coordinator and attended by a variety of local services, such as community nurses, community pharmacists and community matrons. The practice had access to translation services if required. Staff told us that translation services were available for patients who did not have English as a first language. There was no hearing loop available for patients with hearing aids. The practice manager explained that this was investigated in the previous year, together with the patient representatives group, and due to the investigation indicating no evidence of use in four other surgeries and incorporating patient feedback, a decision was made not to have one.

The premises and services were accessible for patients with disabilities. One of the entrance doors was not electronically operated but the receptionist told us that the member of staff working on the front desk would always provide assistance opening the door if required. A bell was present to attract attention. We saw that the waiting area was just large enough to accommodate patients with wheelchairs and prams with enough space in the hallway in case of the waiting room being busy. We were advised the waiting room was not often full. The layout of the building allowed for easy access to the treatment and consultation rooms, with one consultation room having an outside access ramp for wheelchairs in case this was required. The practice informed us they only had one patient that regularly used a wheelchair. Accessible toilet facilities were available for all patients attending the practice. We did not see an alarm cord in the patient toilet. Staff informed us that in case of an emergency they were able to hear shouts for help directly through the door.

A wheelchair use risk assessment was in place. We were provided with evidence that equality and diversity training had been provided to staff and all staff we spoke with were able to explain the core principles.

Access to the service

Appointments were available from 08:00 to 17:00 on Mondays and Thursdays, 07:15 to 18:00 on Tuesdays, 08:00 to 18:00 on Wednesdays and 08:00 to 16:00 on Fridays. Extended hours appointments were offered on Tuesdays. Longer appointments were available for patients who needed them and the practice offered home visits to patients requiring these. Urgent appointments were available on the day and the patient representative group informed us routine appointments were usually available within 48 hours. Comprehensive information was available to patients about appointments on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Appointments with a named GP or nurse were available, practice nurses with special interests in various long term conditions allowed for better access for those suffering with a long term condition. Patients were generally very 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 doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice and routine appointments were generally attended within 48 hours.

The patient survey undertaken by the patient representatives group (PRG) confirmed that 80% of respondents were able to see a doctor or nurse on the same day, or within the next two working days; 10 % responded negative to this and the final 10% couldn't remember. One patient specifically mentioned the easy access to appointments for their children out of school hours. The practice's extended opening hours on Tuesday morning was particularly useful to patients with work commitments. This was confirmed by the PRG.

The practice offered on site minor surgery so that patients who needed this did not need to travel elsewhere to get this done. The practice housed regular external services so that patients requiring these did not need to travel elsewhere. For example, weekly midwife clinics and a bi-weekly obesity clinic.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. As a result lessons learnt from individual complaints had been recognised and acted on in a timely matter. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England; it was available on the intranet for all staff to access at any point. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. This was displayed in the practice and there was a feedback form available on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at two complaints received in the last 12 months and found these were dealt with in an open and transparent manner, providing explanations, referral to the appropriate external body or apologies when required.

There was a suggestion box present in the waiting room, which was monitored by the practice manager. Staff informed us this was not used by patients regularly.

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 staff shared the guiding principle for the practice which included supplying high quality patient care, working towards local and national targets, assurance of patient confidentiality, a focus on delivering and improving services, efficient and motivated healthcare professionals, patient safety, learning from mistakes and seeking patient feedback. This philosophy was shared in the practice through displayed posters in every room. Staff we spoke with all knew and understood the aforementioned principles and knew what their responsibilities were in relation to these.

There was no long term business plan in place and as such we saw no evidence of consideration for future risks recorded in any risk register, for example new local housing that could potentially increase practice demand. The practice told us that matters like this would be discussed with the clinical commissioning group and the neighbouring practices.

Governance arrangements

The practice had a number of protocols, policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice or in paper form. We looked at 12 of these protocols, policies and procedures and all had been reviewed annually and were up to date. There was written confirmation in place claiming staff had read the policies. 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 one the lead GP was the lead for safeguarding. We spoke with four 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 its performance. The QOF data for this practice showed it was performing above national standards in most areas. Staff told us that QOF data was regularly discussed at meetings and action plans were produced to maintain or improve outcomes; we were shown meeting minutes that could evidence this.

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. For example, an audit of diabetes patients around GLP-1 agonist (incretin mimetic drugs) prescribing and an audit on the management of COPD (chronic obstructive pulmonary disease) patients. Both these audits followed a two cycle program and evidenced learning. For example, testing strip for diabetic patients were successfully changed with good results and some COPD patients had their inhaler techniques checked and management plans put in place.

The practice had arrangements for identifying, recording and managing risks; the practice manager showed us risk assessments had been carried out where risks were identified and action plans had been produced and implemented. The risks were not accumulated on a risk log. We saw that the risk assessments were performed regularly and updated in a timely way. Amongst others these included: a work place risk assessment and fire risk assessments. The practice held bi-monthly meetings in which governance was discussed. We looked at minutes from several of these meetings and found that quality and risks had been regularly discussed. During these meetings the significant events (SE) would also be discussed. All staff attended these meetings.

Leadership, openness and transparency

We saw from minutes that multi-disciplinary team (MDT) meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity, and were happy to, raise issues at these meetings. We also noted that team educational meetings were held We reviewed a number of policies, for example the whistleblowing policy, recruitment policy and chaperone policy which were in place to support staff and up to date. Staff we spoke with knew where to find these policies if required.

It was clear from our interviews with the management team, the GPs and the staff that there was an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first. Staff members we spoke with told us they felt their contribution to providing good quality care was valued and that the hierarchal conversation was two ways: the senior staff listened to, and took advice from, all other staff and vice versa. Staff told us that they welcomed the opportunity to raise issues with the GPs and the

Are services well-led?

Good

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

management team. This was also reflected in the arrangements for training staff. Staff felt they had the opportunity to attend additional training and mandatory and regular training was provided.

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

The practice had an active patient representatives group (PRG) which had a steady attendance of five to six regular members. The PRG included representatives from various population groups including young families and older people. The PRG met every quarter and had produced a patient survey for the last three years running, amending the topics to the needs of the patients. The latest survey published in January 2015 showed, amongst others, that 100% of patients had confidence and trust in the doctor/ nurse they saw and 91% and 88% of patients was satisfied with the service provided by the receptionists and dispensary respectively. The results and actions agreed from these surveys are available on the practice website. We saw as a result of the survey that an action plan was implemented, it addressed matters such as the promotion of on-line appointment booking, raising awareness of the option to get SMS text confirmations of appointments and the need to display additional information and guidance around dispensing processes. Acknowledgements were made by the PRG about the good access to urgent and routine appointments.

The practice was effective in supplying all staff with an appraisal process, we saw evidence of all staff having received timely appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff and which was included in the employee handbook amongst many pieces of guidance and information.

According to the GP patient survey the practice was well above CCG average (81% versus 66%) for its satisfaction scores on respondents who usually wait 15 minutes or less after their appointment time to be seen, with 96% of practice respondents saying the last appointment they got was convenient.

The PRG survey raised actions to promote more online registrations following questions around patients' knowledge of booking appointments online, with only 59% acknowledging their awareness of the ability to book online.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had bi-monthly practice/training meetings of which we saw evidence. The nursing team had additional meetings but we only saw minutes of this dating back to March 2014. Clinical staff told us they were supported with protected time to attend developmental events at the local hospital.

The practice had completed reviews of significant events (SE) and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw minutes of practice meetings from the period May 2014 to April 2015 which detailed summaries and current status of actions on SE's. The practice had recently promoted a member of the dispensary to deputy practice manager and was effective in ensuring its staff performed well and developed within a supportive culture.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting (1), the things which a registered person must do to comply with that paragraph include- (g) The proper and safe management of medicines.