Dr Kim Cheung

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 carried out an announced comprehensive inspection at Dr Kim Cheung's practice on 3 December 2014. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement through regular practice meetings. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were well documented, assessed and managed. There were enough staff to keep patients safe and comments received from patients on the day of inspection confirmed this.The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement through regular practice meetings. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were well documented, assessed and managed. There were enough staff to keep patients safe and comments received from patients on the day of inspection confirmed this.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current NICE best practice guidelines. This included assessing capacity and promoting good health. Staff had been encouraged and received training appropriate to their roles. Further training needs had been identified and appropriate training planned to meet these needs. Regular monthly protected training time was available for staff. 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 in the local area 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.

Summary of findings

We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We received 36 completed comment cards that commented positively on the caring aspects of the service that the GP and practice staff, delivered.

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 facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. Staff had received inductions, regular performance reviews and attended staff meetings and had protected time to learn. The GP explained the practice culture as an holistic approach to assess, plan and deliver care and treatment to their patients with the support of their community healthcare colleagues.

Summary of findings

What people who use the service say

We also spoke with six patients who used the service. They were all very complimentary with regards to the staff attitudes towards them, the cleanliness of the facilities and the service overall. We reviewed 36 comment cards where patients and members of the public shared their views and experiences of the service. We received 33 comment cards with positive comments in regards to the service, GP and practice staff. Three cards were less positive. The three completed comment cards with less positive comments did not show any recurring themes.

Dr Kim Cheung

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, and a practice management specialist adviser.

Background to Dr Kim Cheung

Dr Kim Cheung's practice is a single handed GP practice located at Fobbing Road, Corringham, in Stanford-le-Hope, Essex. The practice provides services to approximately 2000 patients living in the local area and holds a General Medical Services (GMS) contract.

The practice is managed currently by a GP. They are supported by a salaried GP, two part-time practice nurses, administrative and reception staff.

The practice is open Monday, Tuesday, Wednesday, and Friday; from 8.30am until 6.30pm and Thursday from 8.30am until 1pm. Consultation appointments were available starting at 9.50am until 12noon and 4pm until 6pm Monday, Tuesday, Wednesday, and Friday, and from 9.50am until 12noon on Thursday. The surgery is closed Thursday afternoons and at the weekends. During these times GP services are provided by South Essex Emergency Doctor Service (SEEDS), an out-of-hours emergency and non-emergency treatment service. Home visits are available as required based upon need.

The practice has opted out of providing GP services to patients outside of normal working hours such as Thursday afternoon, evenings and weekends. Details of how to access SEEDS out-of-hours emergency and non-emergency treatment and advice is available within the practice and on its practice leaflet.

The CQC intelligent monitoring placed the practice in band 6 six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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.

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to

Detailed findings

share what they knew. We carried out an announced comprehensive inspection visit on 03 December 2014. During our visit we spoke with the GP, practice nurse, administrative and reception staff. We also spoke with six patients who used the service. We reviewed 36 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a referral was delayed due to GP annual leave after seeing the patient. This resulted in the referral being delayed by ten days. Incident outcome was; no harm to the patient. As a result of the analysis of this incident a new procedure/policy was put in place to ensure all outstanding referrals were made before GPs go on annual leave.

We viewed the minutes of team meetings and found that safety records and incident reports had been discussed with staff. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standing item on the practice meeting agenda monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken and as a result a new procedure/policy had been put into place to ensure the patient referral process was more effective. 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 by the GP to relevant practice staff. We saw examples of recent alerts that were relevant to patient care and could see that they had been actioned. The GP also told us alerts were discussed at meetings if necessary to ensure all staff were aware of any actions that were relevant to the practice and who was responsible for them.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked a member of the 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 and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had a dedicated GP who was the lead in safeguarding vulnerable adults and children. They had received appropriate training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

The GP used the electronic patient management system to ensure children and young people at risk, or who were the subject of child protection plans were clearly identified and reviewed. The safeguarding GP lead was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The practice monitored the attendance by their patients at the Accident and Emergency department for issues and themes within the different population groups and to

provide support and input with their community healthcare colleagues. The GP told us for example; when a patient with a mental health problem failed to attend for their appointment they always tried to liaise with their key worker or community psychiatric nurse (CPN). A CPN is a psychiatric nurse based in the community rather than at a psychiatric hospital.

Medicines management

We checked medicines stored in the treatment rooms and medicine fridges and found they were stored securely and were only accessible to authorised staff. 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.

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

The nurse administered vaccines using the local clinical commissioning group directives that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directives and evidence that the nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Patients at the practice on these high risk medications were managed by hospital consultants, and the GP checked appropriate action had been taken for patients, based on the hospital results.

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

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Many of the positive comments on the cards we received from practice patients told us how clean they always found the practice.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff received induction training which included infection control specific to their role. They also received annual infection control updates. We saw evidence that the lead staff member had carried out audits for each of the last three years and that any improvements identified for action were completed on time.

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. For example, personal protective equipment 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. There was a list of procedures within the policy that required staff to use protective clothing. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

Are services safe?

references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The GP explained to us how actual staffing levels and skill mix were in line with planned staffing requirements.

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 was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice meetings to ensure all staff members were aware. For example, the car park had become very slippery during recent wet weather with wet leaves covering the surface. To ensure the hazard did not cause an accident a new procedure to sweep the car park during the winter months, whilst the risk existed, was put into operation.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those 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 rated and actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, and access to the building. The document also contained relevant contact details for staff to refer to.

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

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. The GP told us they had planned to recruit a practice manager and would add this practice issue to the risk log.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and Practice Nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that assessments were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GP and practice nurse that clinical staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP had a special interest in diabetes, cardiology and dermatology. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The practice nurse carried out clinics which included Quality and Outcomes Framework (QOF) checks for patients with chronic diseases. 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 e.g. diabetes and implementing preventative measures. The results are published annually.

The GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. We were shown the process the practice used to review patients recently discharged from hospital.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GP uses the national standards for the referral of patients with suspected cancer within two weeks.

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

Management, monitoring and improving outcomes for people

The practice showed us some clinical audits that had been undertaken in the last two years. The GP told us clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). For example, we saw an audit regarding the prescribing of nonsteroidal anti-inflammatory drugs with the aim of reducing their usage. There was also an audit to evaluate the percentage of antibiotics prescribed for upper respiratory tract infection (URTI). As a result, over three a period of three months, the practice had reduced its antibiotic prescribing.

The practice also used the information collected for the QOF and performance against national screening programmes to improve outcomes for patients. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GP had oversight and a good understanding of best treatment for each patient's needs.

The practice was following the gold standards framework for end of life care. It had a palliative care register and had meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending training courses such as annual basic life support. The GP was up to date with their yearly continuing professional development requirements and had been recently revalidated. (Every GP

Are services effective?

(for example, treatment is effective)

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 had received annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties e.g. administration of vaccines, cervical cytology, reviewing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs, including those with more complex needs. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system was effective. We saw that the policy in operation for hospital communications was also effective.

The practice held multidisciplinary team meetings with community nurses, social workers, and palliative care nurses to discuss the needs of complex patients.

Information sharing

Electronic systems were in place for making referrals and the practice made a high proportion of referrals last year through the 'Choose and Book' system. Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A & E.

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

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. 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.

Patients with a learning disability and those with dementia were supported to make decisions. 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 demonstrated a clear understanding of Gillick competencies. Gillick is a competency test 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 a practice policy for documenting consent for specific interventions, for example support and clear guidelines for patients on end of life care

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture for the GP 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. Practice data showed that 35% of patients in this age group took up the offer of the health check. Patients received a follow-up appointment with a GP if the health check revealed any adverse results or risk factors.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering help. For example, the practice kept a register of all patients with a learning disability. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation

Are services effective?

(for example, treatment is effective)

appointments to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care who were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 85% . There was a named nurse responsible for following 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. Last year's performance for all immunisations was above average for the local area and there was a clear policy for following up non-attenders by the named practice nurse.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients had completed comment cards to tell us what they thought about the practice. We received 36 comment cards with 33 cards being positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They told us staff treated them with dignity and respect. Two of the comment cards were less positive but there were no common themes to these. We also spoke with six patients on the day of our inspection. All six told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

There was evidence of listening to a patients concern and taking action, a recent example being where a patient highlighted the car park was slippery due to leaf fall and consequently staff now swept the car park every day.

Within the recent 2014 National GP survey 75% of those patients surveyed said the staff were very helpful. This was the highest rating in comparison with other practices in the local area.

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 confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice telephone was located at the front reception desk. There was no glass partition in place to help keep patient information private although the receptionist confirmed if a patient wanted to speak privately they were called into the rear of reception (back corridor) in order that other patients could not overhear potentially private conversations between patients and reception staff.

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 GP directly. The GP told us he would investigate these and any learning identified would be shared with staff at practice meetings.

There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Staff had undertaken equality and diversity training to raise their awareness of patients whose circumstances may make them vulnerable and what actions could be taken to enable this group to access the practice without fear of stigma or prejudice. Observation of reception on the day of inspection confirmed all patients were treated in a sensitive manner. Training certificates were evidenced in staff records for equality and diversity training.

Care planning and involvement in decisions about care and treatment

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

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received were positive about the emotional support provided by the practice and rated it well in this area. Specifically, the patients we spoke with were able to give examples of services they had been signposted to for help with the management of their care and treatment. Staff confirmed they had received training to support those people with caring responsibilities.

Notices in the patient waiting room advised people how to access a number of support groups and organisations. The practice computer system alerted the staff if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Are services caring?

The GP told us that if families had suffered a bereavement they preferred a personal approach and usually contacted the family to see if they would like a home visit at a flexible time to ascertain the family's needs.

There was a pro-active approach to recognising the needs of older people with long term conditions, families, children and young people. These groups were given priority and offered appointments at a time that suited them. If necessary their care was co-ordinated with other services for example; district nurses, the rapid response team, community matrons, community psychiatric nurse and the Macmillan nursing team. Two patients, particularly, with higher levels of need and with whom we spoke on the day of our inspection, confirmed they had received excellent care and support and were made aware of help and support they could access.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The GP told us during meetings with Clinical Commissioning Group colleagues (CCG), area challenges were discussed; this intelligence helped them to respond and deliver their service to the practice population that met their needs. For example, they monitored the admissions to A & E for themes to determine support needs. CCG's are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example those with a learning disability.

The practice had access to telephone translation services for patients whose first language was not English.

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.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was located in a purpose built property with wide entrance doors and a car park to the front of the building ensuring good access for disabled, prams and wheelchair users. The practice had wide corridors for easy access to the treatment and consultation rooms patients with mobility aids. This made movement around the practice easier and helped to maintain patients' independence. Dedicated parking bays for those with limited mobility.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and allowed for prams and pushchairs. Accessible toilet facilities including facilities for the disabled were available for all patients attending the practice.

Access to the service

Appointments were available from 9.50am until 12noon and 4pm until 6pm Monday, Tuesday, Wednesday, and Friday, and from 9.50am until 12noon on Thursday.

Patients we spoke with on the day of inspection told us that they were able to book urgent appointments on the same day they requested them. They also said they could see another GP if there was a wait to see the GP of their choice.

Comprehensive information was available to patients about appointments on the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments. 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.

Longer appointments were 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 a local care homes on request by a named GP to those patients who needed one.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Information was displayed in the waiting room and on the practice leaflet to explain the practice system to patients. 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.

The practice had not received any complaints in the last 12 months. The practice had a process and procedure to deal with complaints that met the recognised guidance.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear philosophy to deliver high quality care and promote good outcomes for patients. We found details of the practices' vision and objectives which included statements in connection with: Quality of care, environment, professional quality, staff and communication.

Staff spoken to knew about the existence of the document and understood what their role and responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in folders at reception. We looked at 16 of these policies and procedures which had been reviewed and signatory sheets confirmed most staff had read the policy and when. With the exception of three policies we looked at they had all been reviewed annually and were up to date.

The GP told us because this was a small practice with few staff there was a family environment and leadership structure. Staff members confirmed they were all clear about their own roles and responsibilities and felt they could approach the GP about any topic. They also told us they felt valued, well supported and knew the GP was the first point of contact in most instances 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 in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The GP advised peer reviewing was undertaken through the local clinical commissioning group and confirmed this year they had been monitoring A&E attendance and prescribing. Peer reviewing in this situation is the evaluation of the monitoring of A&E attendances and prescribing work the practice was undertaking by one or more GP practices in the local area.

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 infection control.

The practice had robust arrangements to identify record and manage risks. The GP showed us the risk log, which addressed a wide range of potential issues, such as the slip risk in the car park. We saw that the risk log was discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified; actions had been taken and implemented to reduce the risk. For example the staff now swept the car park every day in the winter to ensure the risk is reduced.

Leadership, openness and transparency

We saw from minutes that team meetings were held and staff confirmed they saw sight of these minutes. 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 held monthly. The minutes confirmed staff issues had been raised and evidence was found of action being taken to address these concerns. We saw staff members had the opportunity during the half day closing once a month to undertake e-learning.

We reviewed a number of policies for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. Staff were able to point out where these policies were kept. We were shown the hard copy of the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The GP at the practice advised they took all feedback seriously as it helped the practice to learn and improve. The practice had not gathered any formal feedback from staff through surveys but encouraged staff to give their opinions during practice meetings. This was evidenced in the minutes of staff meetings. The staff also 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.

Are services well-led?

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook.

There was a suggestion box in the reception area to collect patient's comments complaints and compliments. We were told that complaints that had been received by the practice had not been put into the suggestion box. The GP told us patients would talk to him informally at a personal level if there was a problem or issue and would resolve it if he was able.

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 three staff files and saw that regular appraisals took place which included a personal objectives plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example increased prevention measures in an area of known patient risk.