The Lawns 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 carried out an announced comprehensive inspection at The Lawns Surgery on 28 April 2015. The Lawns Surgery provides primary medical services to people living in Rustington, Littlehampton, East Preston and Angmering. At the time of our inspection there were approximately 2,000 patients registered at the practice with a team of a principal GP, a part time salaried GP, a practice nurse, a healthcare assistant, a small team of receptionists / administrative staff and a practice manager.

The practice has an overall rating of good.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Test results were communicated with patients as soon as possible, usually the following day.
- 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.
- GPs printed out consultation notes for patients including medication information so that patients could review their care and treatment
- Medicine information including name of medication, dosage and reason for taking it was given to patients and where appropriate was printed in large text for those with visual impairments.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Patients said they found it easy to make an appointment with their GP and that there was continuity of care, with urgent appointments available the same day.
- The practice was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- There were effective systems in place for the controlling the risk of infection. The practice was clean and hygienic.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.

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 the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. GPs printed out consultation notes for the patients with complex needs which included discussions had on medicines so that the patient could review their care and treatment. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with local multidisciplinary teams to provide patient centred care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients told us the GPs provided continuity of care and had contacted them outside of normal working hours to provide information and support. For example, the GPs ensured that blood test results were communicated with the patient as quickly as possible, usually the morning following a blood test and patients told us they were even contacted at the weekend. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with

Summary of findings

kindness and respect, and maintained confidentiality. During the inspection we witnessed caring and compassionate interactions between staff and patients. Patients told us that they never felt rushed in consultations and appreciated the time the GP took with them. Patients had access to local groups for additional support.

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 local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment 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. There was evidence of shared learning from complaints with staff and patients. Patients with disabilities were able to easily access the practice. Home visits and telephone consultations were also available.

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 meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff we spoke with told us they felt valued and were appreciated. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.

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 patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, for dementia and end of life care. All patients over 75 years of age had a named GP for continuity of care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. The practice also supported patients at several care homes. Carers were highlighted on the practice's computer system and they were given information about the local carers support team. The practice used computerised risk stratification tools to identify patients at risk including those at risk of hospital admissions. Those patients were included on an admissions avoidance register and patients had a personalised agreed care plan. The practice received daily information of any patients on this register being discharged from hospital so that they could be contacted within three days to discuss their care and treatment needs. The practice worked closely with multidisciplinary teams to plan care accordingly. Patients requiring multi-disciplinary intervention were included on the Proactive Care Scheme and had an agreed care plan. Fortnightly meetings were held at the practice to ensure a joined up approach with other health teams which included community nurses, physiotherapist and social services. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Clinics included diabetic reviews, blood tests and the practice also offered blood pressure monitoring. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients.

People with long term conditions

Good

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

worked with relevant health and care professionals to deliver a multidisciplinary package of care.Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. There were regular immunisation clinics for babies and children with systems in place to follow-up non-attenders. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be seen on the day. Specific services for this group of patients included family planning and antenatal clinics.

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 had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Patients were able to request a GP to telephone them instead of attending the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Travel advice appointments were offered at times convenient to the patient. Patients were also given smoking cessation advice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. The practice was able to support those patients with an opiate dependency. The practice offered longer appointments for patients when required. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out

of hours. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. The practice supported patients who were registered as a carer.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice was able to refer patients to "Time to Talk" counselling service. Patients with severe mental health needs had care plans and received annual physical health check. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. We noted that clinical staff had attended recent training in the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 4 comment cards which contained positive comments about the practice. We also spoke with five patients on the day of the inspection.

We reviewed the results of the national patient survey from 2014 which contained the views of 128 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 95% of respondents found it easy to get through to the surgery by phone, 92% said the last GP they saw or spoke with was good at giving them enough time and 96% said they had confidence and trust in the last GP they saw or spoke with. All of these scores were well above the average local Clinical Comissioning Group (CCG).

The practice provided us with a copy of the practice patient survey results from 2015. Results showed that 98% of patients thought they were treated with care and concern. When asked the question if they felt the GP listened to them 91% said they agreed. 100% of patients thought the GP was good or very good at explaining tests and treatments and 100% of patients thought the nurse was good or very good at involving them in decisions about your care

We spoke with five patients on the day of the inspection and reviewed 4 comment cards completed by patients in the two weeks before the inspection. Comments we reviewed and the patients we spoke with were positive about the practice and the care they received. Comments included that patients felt cared for, respected and two patients commented that staff interacted and explained things well with their children. Comments also included that staff were professional, friendly, caring and they listened to the patients. Patients told us the GPs provided continuity of care and had contacted them outside of normal working hours to provide information and support. For example, the GPs ensured that blood test results were communicated with the patient as quickly as possible, usually the morning following a blood test and patients told us they were even contacted at the weekend. All of the patients we spoke with told us they felt the practice had supported them through all of their health needs and that of their family members. Patients also told us that they never felt rushed in consultations and appreciated the time the GP took with them.

The Lawns Surgery

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 Manager specialist.

Background to The Lawns Surgery

The Lawns Surgery is situated in the grounds of Zachary Merton Hospital and offers general medical services to the patients in Rustington, Littlehampton, East Preston and Angmering. There are approximately 2,000 registered patients.

The practice is run by a GP who is supported by a part time female salaried GP, a practice nurse, a healthcare assistant, a small team of receptionists / administrative staff and a practice manager.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and holiday vaccinations and advice.

Services are provided from:

Zachary Merton Hospital, Glenville Road, Rustington, West Sussex, Littlehampton, BN16 2EA

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a higher number of patients between 60 and 85 years of age than the national and local CCG average, with a significant higher proportion of 65-69 year old and over 85 year olds. There are a higher number of patients with a caring responsibility and the percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the average for England.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the NHS Coastal West Sussex Clinical Commissioning Group (CCG). We carried out an announced visit on 28 April 2015. During our visit we spoke with a range of staff, including GPs, nurses and administration staff.

We observed staff and patients interaction and talked with five patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 4 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

Detailed findings

- 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Staff told us that they were able to discuss significant events, incidents or complaints as they arose but these were also formally discussed at team meetings. There was evidence that the practice had learned from these and that the findings were shared with all staff. Staff, including receptionists and administrators knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents and significant events. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a referral to a counselling service was made for a patient; however the patient called the practice after four weeks because they had not heard from the organisation. The practice contacted the counselling service and it was discovered that the referral system had changed. All referrals needed to be made through a referral form and the patient needed to call the organisation to activate the referral. We noted that all staff were made aware of the new process and the required forms. The practice also ensured they had a supply of the counselling service leaflet that explained the process to give to patients when making a referral.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings and if needed during one to one meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw an example of an alert for the withdrawal of a medicine for nausea. The practice had reviewed the patients on this medicine and had requested they saw the GP for a medicine review.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young patients and vulnerable adults. GPs could demonstrate they had the necessary training to level 3 safeguarding children. All the staff we spoke with could demonstrate they understood safeguarding issues and identify concerns. They were all aware of the protocols and process to follow and knew who to speak with if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible.

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

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. Nursing staff, including health care assistants, could be asked to be a chaperone. All staff undertaking these duties had received a criminal records check through the Disclosure and Barring Service. We saw there were posters on display within the clinical rooms and waiting room which displayed information for patients about how to request a chaperone.

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

Good

Are services safe?

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators 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. Staff were able to tell us of what they would do if there was a problem with a medicine refrigerator.

The practice had processes 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. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

There was evidence that the practice undertook regular reviews of prescribing data in conjunction with the clinical commissioning group (CCG) which set annual prescribing targets as part of an incentive scheme. For example, patterns of antibiotic, and sedatives prescribing within the practice.

The GPs took ownership of their patient repeat prescription requests and patient medicines reviews were organised in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. Blank prescription forms were stored securely and were tracked through the practice in accordance with national guidance.

Patients at the practice were able to request that local chemists could pick up their prescriptions. The practice had systems in place to monitor how these prescriptions were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Vaccines were administered by nurses using 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 nurse had received appropriate training to administer vaccines.

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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed in a timely manner.

An infection control policy and supporting procedures were available for staff to refer. This enabled staff 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. 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.

We spoke with the practice manager regarding the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The practice was situated on the grounds of Zachary Merton Hospital and it was the role of the estate management team to complete legionella testing. We saw records which confirmed that legionella testing had been carried out for the practice.

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 the maintenance and calibration of relevant equipment; for example weighing scales, 24 hour blood pressure monitors and nebulizers (equipment used to administer medicines which are inhaled).

Staffing and recruitment

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

We noted there was polices and protocols in place for when the practice used locum staff. For example, the practice policy for using locums highlighted all of the necessary employments checks that needed to be completed before starting work at the practice.

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 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 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.

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 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.

We saw that any risks were discussed at practice meetings and within team meetings. For example, the findings from the infection control audit were shared with the team.

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 all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. 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.

An emergency and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, staff shortages and access to the building. The document also contained relevant contact details for staff to refer to. We noted the practice had a mutual aid arrangement with two neighbouring practices. For example, the other practice could help in the event of the not being able to use the building.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP 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 these actions 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 that staff were expected to completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We noted the practice nurse undertook the lead role in diabetes and attended bi-monthly meetings with specialist nurses for diabetes which ensured she could discuss the most up to date information and guidance.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. This included those at risk of hospital admissions. Those patients were included on an admissions avoidance register and we saw those patients had a personalised agreed care plan. The practice received daily information of any patients on this register being discharged from hospital so that they could be contacted within three days to discuss their care and treatment needs.

The practice worked closely with multidisciplinary teams to plan care accordingly. Patients requiring multi-disciplinary intervention were included on the Proactive Care Scheme and we saw patients had an agreed care plan.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice used national standards for the referral into secondary care. For example, suspected cancers were referred and seen within two weeks.

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

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

Clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, an audit had taken place following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding the prescribing of a particular anti-nausea medicine. Following the audit, the GPs carried out a medicine reviews for any patients who were prescribed this medicine and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100 % of patients with diabetes had received the flu jab and 91% had a record of retinal screening in the preceding 12 months. We also noted that 92% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional; including an assessment of breathlessness in the preceding 12 months and that 100% of patients aged 75 or over with a fragility fracture, were currently being treated with an appropriate bone-sparing agent. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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. In line with this, staff regularly checked that patients receiving repeat prescriptions had

Good

Are services effective?

(for example, treatment is effective)

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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. The practice worked closely with the local pro-active team and held fortnightly meetings. (The local pro-active team included community nurses, physiotherapist, social services, community mental health nurse, occupational therapist and pharmacist).) We saw that care plans were created with the input of the patient. Patients were also highlighted on the practice computer system so that their care could be prioritised.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, fire awareness and safeguarding. The 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. Staff we spoke with told us they felt that appraisals were useful and gave them the opportunity to discuss any concerns they had, their performance and any future training needs.

The practice nurse was expected to perform defined duties and we saw evidence that demonstrated they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and diabetes care.

We noted there was polices and protocols in place for when the practice used locum staff. We reviewed the locum information pack. This gave an overview of the staff members, their roles and the practice, as well as clinical working guidance relevant to the practice. For example, who could be used as a chaperone and where the medical emergency equipment was situated.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with 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 service both electronically and by post. The GP and relevant staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

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. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. The practice held meetings with the local hospice every 6 to 8 weeks and separate health visitor meetings as well as fortnightly pro-active care meetings. The pro-active care meetings were attended by community nurses, physiotherapist, social services, community mental health nurse, occupational therapist and pharmacist. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used a referral system for patients requiring specialist treatment. The GPs completed these referral requests which we noted were done in a timely manner. The GPs spoke with patients as to where they would like their consultation to be before organising the referral. Patients we spoke with confirmed that this happened and appreciated that referrals could be made during their consultation.

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 staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff we spoke with highlighted how patients should be supported to make their own decisions and how this would be documented in the medical notes. We saw evidence that the clinical staff had received training for the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties (DoLs) in November 2014

Care plans were used to support patients to make decisions regarding their care. These care plans were reviewed 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. The GPs demonstrated a clear understanding of Gillick competencies. (Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The GP we spoke with told us they always sought consent from patients before proceeding with treatment. They told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. The GP also printed out the notes of the patient consultation and discussions had on medicines so that the patient could review their care and treatment. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures written consent was required and a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice ensured that consent was obtained by the patient if they wished for other people to have access to their medical information. For example, for a family member to receive test results on behalf of a patient or for patients who have no fixed abode to use a friends contact details so the practice can contact them if necessary.

Health promotion and prevention

It was practice policy to offer a health to all new patients registering with the practice. New patients had an initial assessment with the healthcare assistant and then an appointment with GP. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic offering smoking cessation advice to smokers and reminding patients who were overdue cervical screenings.

The practice recognised it had a high number of patients from Portugal. To support these patients the practice had organised a healthy living initiative which included information in relation to lifestyle choices and advice.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of patients with poor mental health and 88% had seen a GP for an annual review and had a comprehensive care plan agreed.

The practice had identified the smoking status of 92% of patients over the age of 16 and we noted that 92% of those patients recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 100% of

Good

Are services effective?

(for example, treatment is effective)

children aged below 24 months had received their mumps, measles and rubella vaccination. The practice's performance for cervical smear uptake was 96%, which was above the national average. We also noted that 75% of patients aged 65 and older who had received a seasonal flu vaccination. There was a mechanism in place to follow up patients who did not attend screening programmes.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 98% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 93% of practice respondents saying the GP was good at listening to them and 92% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 96% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 97% said the same about the last nurse they saw.

We also reviewed a practice patient survey from 2015 of which the practice. Results showed that 98% of patients thought they were treated with care and concern by the doctor and 97% by the nurse. When asked the question if they felt the GP listened to them 91% said they agreed and 97% said they felt the nurse listened to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all were positive about the service experienced. Patients we spoke with told us they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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. All of the patients we spoke with told us they felt the practice had supported them through all of their health needs and that of their family members. Patients also told us that they never felt rushed in consultations and appreciated the time the GP took with them.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. We also noted that music was played in the waiting area which all helped to protect patient privacy. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above average compared to the Clinical Commissioning Group area. The results from the practice's own satisfaction survey showed that 100% of patients said they felt the GP explained things well and 92% of patients felt they were involved in decisions about their care. When asked if patients thought the nurse involved them in decisions about their care 100% said it was either good or very good.

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. The GP we spoke with told us that they could print out the notes of their consultation with the patient to ensure that could review what they had spoken about and where appropriate the different actions that could or had been taken. Patients

Good

Are services caring?

we spoke with confirmed this and told us this helped them to make decisions about their care and treatment and ensured they understood why they had been prescribed their medication.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website also had the functionality to increase the font size of the web pages.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 86% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 94% of patients said the nurses were also good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting rooms 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. We were shown an information board in the waiting area which contained information for carers to ensure they understood the various avenues of support available to them.

Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. The GP could contact family members and if needed arrange a home visit. Staff told us that they knew patients well and a patient's death was always handled sensitively. Staff could also arrange a patient consultation at a flexible time and could give them advice on how to find support services.

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. For example, patients over the age of 65 years of age made up more that 60% of the patients attending the practice. The practice ensured that patients had sufficient time to express their concerns and offered routinely 20 minute appointments to this population group. The GPs also ensured that detailed written instructions were given to patients regarding their medication including the name of the medicine, the amount to be taken and at what intervals as well as the reason for taking it. The GP's also requested that the patient's pharmacy printed out instructions in large print and capital letters for those patients with impaired vision.

Patients with more complex needs were given print outs of their consultation with the GP so that they could review what was discussed and any medication requirements. We noted that all blood tests results were normal communicated with the patient the following day after their test. All the patients we spoke with commented that they appreciated this service from the GP and some told us that (with their permission) the GP had contacted them at the weekend to ensure that they were not worrying about the results.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had received comments that patients sometimes had to wait before seeing the GP. In response to this the practice had included catch up sessions in the GP schedule. This was to help ensure that patients did not have to wait for long periods of time.

Longer appointments were available for patients who needed them and for those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Patients were able to book appointments and order repeat prescriptions on line.

The practice supported patients with complex needs and those who were at risk of hospital admission. The practice worked closely with the local proactive care team which included district nurses and health visitors. Personalised care plans were produced and were used to support patients. Patients with palliative care needs were supported. The practice had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs.

The practice provided care for patients with mental health problems in local residential care homes as well as for patients with dementia in residential care homes. The practice was also providing care for patients at the local community hospital and conducted regular ward rounds.

Patients with long term condition had their health reviewed in an annual review. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health. Childhood immunisation services were provided with administrative support to ensure effective follow up. Post natal and six week check were provided at the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required.

We noted that some staff had received equality and diversity training and others were booked onto training in June 2015.

The practice was situated in the grounds of Zachary Merton Community Hospital and consisted of a single story prefabricated building. We noted patients had access to the front entrance of the practice via a slope; however the practice did not have doors which had an automatic opening mechanism. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Several chairs had arm rests to aid patients when getting up from their seats. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available Monday, Tuesday, Wednesday and Friday 8am to 6:30pm and on a Thursday 8am to 2:30pm. There were extended hours on a Monday morning from 7:30am to 8am and on a Wednesday evening 7:30am to 7pm. The front desk remained open at lunch times for prescription collection and enquiries. Appointments could be booked up to three months in advance and there was on-line booking facilities available.

There was comprehensive information available to patients about appointments on the practice website and in their practice leaflet. 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.

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits could be arranged and GPs visited several local residential and care homes.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Comments received from patients showed that patients had often been able to make appointments on the same day of contacting the practice. All the patients we spoke with on the day of inspection told us they had been able to get appointments at a time convenient to them.

We noted data from the national patient survey 2014 indicated that 99% of respondents said the last appointment they received was convenient**.** Results from the practices own survey indicated that patients were happy with the appointment system with 97% of respondents being able to get an emergency appointment on the same day. On the day of inspection we asked staff when the next available appointment would be for a non-emergency appointment with a particular GP and a cervical screening appointment with the nurse. The appointment system showed that the next (non-urgent) appointment free for the doctor was in two days' time and the nurse was in one weeks' time.

Listening and learning from concerns and complaints

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

Complaints information was made available to patients in the practice and on the practice website. Friends and Family test suggestions boxes were available within the patient waiting area which invited patients to provide feedback on services provided, including complaints. None of the patients we spoke with had ever had cause to complain. We reviewed three complaints received during 2014. We found these were handled in a timely way with openness and transparency. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff. The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 staff we spoke with told us that they felt well led. All the staff we spoke with told us there was a 'no blame culture' in the practice and they felt that senior staff members were always available to talk with. The practice was clinically well led with a core ethos to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose included the statement to provide preventative care and health education to its patients. Staff we spoke with told us the vision of the practice was to provide a service they would expect and want if they were patients at the practice. With rapid access to appointments, investigations and results and quick timely referrals to secondary care.

The practice manager and GP told us they felt the building was no longer able to accommodate the needs of their patients. They explained that part of the vision for the practice was to move to more suitable premises which had been located but the move date was yet to be decided due to circumstances beyond their control.

We spoke with six members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these. Staff spoke very positively about the practice, they told us there was good team work and they were actively supported to provide good care for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of the policies and procedures and found they were up to date and held relevant information for staff. This included the confidentiality protocol, infection control and safeguarding children policy.

There was a clear leadership structure with named members of staff in lead roles. We spoke with six 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 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 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, the practice had completed audits in relation to the use of human insulin for type two diabetes; patients with chronic obstructive pulmonary disease (COPD) and a review of patients prescribed a medicine to help stop the clotting of blood.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a recent risk assessment had been discussed with staff in relation to the cords used to open and close the window blinds within the practice. This had highlighted the need to position the cord out of a child's reach to prevent injuries.

The practice held regular meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly with all staff members. Notes were recorded so that staff who were unable to attend could be updated with discussions had. Staff told us that senior staff would discuss concerns, significant events or complaints outside of these meetings if necessary. They told us that these discussions meant that they could be offered support or advice straight away. There was an open culture within the practice and staff told us they were happy to raise issues and felt encouraged to do so. Staff told us that social events had been arranged by the practice. These events were used for senior staff members to thank staff for their work and provided an opportunity for reflection.

We saw there were a number of human resource policies and procedures in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on bullying, sickness and lone

Are services well-led?

Good

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

working. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and knew the practice and senior team members would take their concerns seriously and support them. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, patients comment and complaints received. The practice manager showed us the analysis and action plan of the last patient survey in February 2015. For example, due to comments made by patients in relation to appointments available, the practice had increased the number of GP appointments by opening on some Thursday afternoons when the surgery would normally be closed. The practice was also in the process of increasing the number of surgery appointments offered with the principal GP on a weekly basis. The results and actions agreed from these surveys were available on the practice website and the most recent survey results were on display in the waiting area

The practice was advertising for patients to join as members of the patient participation group (PPG). We saw this was advertised on the practice website and through posters in the waiting room. The practice manager was also talking with individual patients to explain the purpose pf the group and pass on more information.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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 electronically on any computer within the practice. Staff we spoke with told us they would have no concerns in using the policy to protect patients if they thought it necessary.

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 staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had regular training either organised with the local clinical commissioning group or by the practice. We saw evidence of protected learning events throughout the year. The practice was closed for these events and patient queries and appointment times were covered by the Out of Hours provider.

The practice had completed reviews of significant events, complaints and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients and could discuss better ways of working. For example, we noted that a significant event had been raised due to blood samples being left in a surgery overnight. We saw that this had been discussed with staff and the process reviewed. All samples were now placed in a secure container at the end of each surgery and a visual check of all rooms was completed by a staff member before the samples were collected.