Maple 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 visited Maple Surgery on 27 April 2015 and carried out a comprehensive inspection. We found that the practice provided a safe, effective, caring, responsive and well led service. The overall rating for this practice is good.

We examined patient care across the following population groups: older people; those with long term medical conditions; families, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups.

Our key findings were as follows:

- The practice addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- Patients were able to get an urgent appointment the same day if they needed to be seen urgently.
- Patients were treated with dignity and respect. They were involved in decisions about their care and treatment.
- The practice was friendly and responsive. Nationally reported feedback from patients was below average in a number of areas but the practice were aware of this and had a plan in place to make improvements in these areas.
- The needs of patients were understood and services were offered to meet these.
- The practice used the benefits of being part of a large organisation, whilst retaining the individuality of being a small practice.

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

- Ensure that cleaning records are maintained and spot checks of cleaning are documented.
- Improve the follow up of vulnerable patients who did not attend for their appointment.

Summary of findings

- Improve arrangements for providing patients with information about the complaints process, including how to escalate complaints if they remain dissatisfied.
- Ensure that all policies, including the business continuity plan, are up to date and adapted to Maple Surgery.
- Ensure that the actions identified for improving patient satisfaction rates are prioritised and their impact reviewed.

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 report incidents and near misses. Lessons were learned from significant events and complaints and communicated across the Malling Health (UK) Ltd practices in the area to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Staff had a good understanding of the types of abuse and their responsibilities in relation to safeguarding. Information was provided to support staff in relation to safeguarding children and adults. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. We saw evidence of effective multidisciplinary working.

Staff had received training appropriate to their roles and further training needs had been identified and planned for. Staff received regular appraisals.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice in line with others in the same clinical commissioning group (CCG) area, for several aspects of care. In some areas they were rated below the CCG average. Practice survey data completed in July to August 2014 showed higher ratings than the CCG data for some of these areas. An action plan was in place to improve approaches to patients and customer satisfaction. All of the patients we spoke with and received comments from said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with NHS England

Summary of findings

and the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. The practice offered early morning appointments on a Monday, Wednesday and Thursday. The practice had good facilities and used their premises as effectively as possible. They were well equipped to treat patients and meet their needs. There was a complaints system in place with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and staff were aware of their responsibilities in relation to this. There was a clear managerial and clinical leadership structure and staff we spoke with felt supported in their work. The practice had a number of policies and procedures to govern its activity, although there were some gaps in two of the policies we looked, where they had not been adapted to the practice. Regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, appraisals and attended staff meetings and peer support meetings.

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 the practice had good outcomes for conditions commonly found amongst older people. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. We saw that care plans were in place and health checks for patients over the age of 75 had taken place. There was a good uptake of influenza and shingles vaccination, which was above the national average. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. Regular multi-disciplinary meetings including the GPs and district nurses took place to discuss the needs for older people with complex needs, and those at the end of their life, to ensure they received co-ordinated and well planned care.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice maintained registers of patients with long-term conditions and national data showed that the practice scored well for its management of long-term conditions such as asthma and arthritis. When patients on this register contacted the practice they received a call or a visit from a GP that day. All patients with long term conditions had structured reviews, at least annually, to check their health and medication needs were being met. For those people with the most complex needs the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available.There was good information about a range of long term health conditions in the practice's waiting room, making it easily accessible to patients.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. The practice's waiting area was large enough to accommodate patients with prams and accessible toilets with baby changing facilities were available for all patients attending the practice. Appointments were available outside of school hours. A midwife led clinic was available for patients which was held at the practice. A recall system was in place for the mother and baby six

week check. The practice completed preschool checks for all children registered at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Systems were in place for identifying children living in disadvantaged circumstances and who were at risk. The practice had a dedicated administrator who was responsible for monitoring children at risk and who, at the time of our inspection, had started to organise monthly meetings with local health visitors, midwives and school nurses to ensure a co-ordinated approach to their care.

Childhood immunisations were offered and there was good uptake of these. There was scope to improve the follow up of children who had been identified to the practice by Child Health Cambridge as not receiving their immunisations. Child Health Cambridge is the organisation who have oversight of children who have not attended for their immunisations in the Cambridge area.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were met. Patients had the facility to book appointments, request repeat medication and access their summary care record on-line. The practice offered a range of appointments which included on the day and pre-bookable appointments, as well as telephone consultations with the GP. The lead GP also encouraged patients to send photos via email for on the day diagnosis if appropriate.

Extended hours appointments were available three days a week, providing early appointments from 7 a.m. to avoid disruption for working patients. The practice also remained open to patients over the lunchtime period. The practice's prescription service allowed people to collect their medication from the pharmacy of their choice.

The practice offered a full range of health promotion and screening which reflects the needs for this age group. Cervical cytology screening was undertaken by the nurse and female GP and contraceptive services were available from a female GP. The latest national data showed that the uptake of cervical screening for female patients was above the average for the local area at 84%.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held registers for different groups of people living in vulnerable circumstances and there was a system for flagging vulnerability in patients' individual records. Vulnerable patients were highlighted when they had attended A&E or out of hours services and were contacted by the practice on the same day and offered contact with GP either by an appointment or telephone consultation.

There was a named lead in the practice for safeguarding and all staff had received training in how to protect vulnerable adults and children at a level appropriate for their role. 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 and out of hours. The practice also held its own domestic abuse register and there was a dedicated area in the waiting room providing information and resources to women experiencing domestic abuse.

Nationally reported data showed the practice performed above the Clinical Commissioning Group (CCG) and England average for people with a learning disability. The practice held a register of patients with a learning disability and at the time of our inspection, 54% had received an annual health check. There was scope to improve the follow up of patients with a learning disability who did not attend for their annual health check.

We were told that longer appointments were given to patients who needed more time to communicate during a consultation, for example people who needed an interpreter. There were arrangements for supporting patients whose first language was not English.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Nationally reported data showed the practice scored above the Clinical Commissioning Group (CCG) and England average for people with mental health needs, including those with dementia. The practice held registers of people with mental health needs, including those with dementia. People experiencing poor mental health received regular health and medication reviews to ensure appropriate treatment was in place. The practice worked closely with members of the local community mental health teams to ensure people received appropriate support. The practice had a system in place to follow up patients who had attended accident

and emergency (A&E) where they might have been experiencing poor mental health. There was information about a range of mental health support agencies available to patients in the practice's waiting area.	

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection. All of the patients told us that they were able to get an appointment easily and felt that they had sufficient time with the GP. Patients we spoke with confirmed that they were treated with privacy and dignity and were involved in decisions about their care and treatment. Patients reported that they received regular checks for their health conditions. None of the patients we spoke with had any concerns about the practice.

We collected six Care Quality Commission comment cards from a box left in the practice one week before our inspection. All of the comments on the cards were positive about the practice. Patients reported that the staff were friendly and helpful and that doctors were thorough and gave them enough time.

After the inspection we spoke with three members of the Patient Participation Group (PPG)which disbanded in November 2014. They told us that they felt the PPG had come to its natural end, particularly as Maple surgery were not as involved in the PPG as the previous practice had been. They said that Maple Surgery had responded to suggestions they made which had improved the practice.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that cleaning records are maintained and spot checks of cleaning are documented.
- Improve the follow up of vulnerable patients who did not attend for their appointment.
- Improve arrangements for providing patients with information about the complaints process, including how to escalate complaints if they remain dissatisfied.
- Ensure that all policies, including the business continuity plan are up to date and adapted to Maple Surgery.
- Ensure that the actions identified for improving patient satisfaction rates are prioritised and their impact reviewed.

Maple Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP Specialist Advisor. The team also included a practice manager specialist advisor and another CQC inspector.

Background to Maple Surgery

Maple Surgery, in the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area, provides a range of alternative primary medical services to approximately 3600 registered patients living in Bar Hill and the surrounding villages.

According to Public Health England information, the patient population has a slightly higher than average number of patients aged 0 to 4 and a slightly lower than average number of patients aged 5 to 18 compared to the practice average across England. It has a slightly lower number of patients aged 65 and over, aged 75 and over and aged 85 and over compared to the practice average across England. Income deprivation affecting children and older people is significantly lower than the practice average across England.

The practice is provided by Malling Health (UK) Ltd, a limited partnership, based in Kent. Malling Health UK Ltd hold managerial and financial responsibility for the practice. They took over responsibility for the practice two years ago. They employ three GPs, (2.1 whole time equivalent), one practice nurse (1.0 whole time equivalent) and one health care assistant (0.5 whole time equivalent). There is also a team of reception staff, led by a senior receptionist a deputy manager and a locality manager.

The practice provides a range of clinics and services, which are detailed in this report, and opens between the hours of 7:00am and 6:30pm, Monday, Wednesday and Thursday and between 08:30am and 6:30pm on Tuesday and Friday.

Outside of practice opening hours a service is provided by another health care provider Cambridgeshire and Peterborough 111, by patients dialling the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the

Detailed findings

service. We talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch. The information they provided was used to inform the planning of the inspection.

We carried out an announced visit on 27 April 2015. During our visit we spoke with a range of staff, including two GPs, one practice nurse, one health care assistant, three reception staff, the deputy practice manager, the locality manager and the area manager.

We spoke with seven patients who used the practice. We reviewed six comments cards where patients had shared their views and experiences of the practice.

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

- 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

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. There were records of complaints and significant events that had occurred during the last two years and we were able to review these. These had been kept since Malling Health (UK) Limited took over responsibility for the practice two years ago. For example one significant event related to duplication of repeat prescriptions. This was resolved by identifying a prescription clerk who would hold accountability for repeat prescriptions. We noted that an annual review of complaints and significant events had taken place to ensure that learning from them had taken place and to prevent their reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including receptionists and clinical staff were aware of the system for raising significant events and felt encouraged to do so. Significant events and complaints was a standing item on the monthly clinical meeting agenda and we saw evidence that significant events and complaints were discussed and actions from past significant events and complaints were reviewed.

We looked at the records of significant events and saw these had been completed in a comprehensive and timely manner. We looked at three significant event analyses and saw evidence of action taken as a result. One significant event related to inappropriate hospital transport being booked for a patient, which resulted in the patient missing their appointment. We saw that guidelines were in place for staff to follow when requesting hospital transport to ensure the correct transport was arranged according to the patients' needs. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff via the monthly clinical meetings and the administration meetings which were held every two months.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example one related to the use of a medication to relieve feelings of sickness or vomiting which might be harmful to the heart. We saw that all patients on a repeat prescription were reviewed and their treatment stopped or changed appropriately and this was justified in the patient's notes. Staff also told us alerts were discussed at the monthly clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had a range of documentation to advise staff of their role and responsibility in relation to safeguarding children and vulnerable adults. This included safeguarding adults and safeguarding children's policies, contact information for safeguarding professionals external to the practice and flow charts for making a safeguarding referral. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their safeguarding knowledge. 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 to staff at the practice as these were displayed in the administration, clinical and consultation rooms.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained to level three and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plan. The practice also had a receptionist who was responsible for keeping a children's safeguarding register to record those children who were on the child

protection register and those who were 'at risk'. There was a process in place for following up children who did not attend for their immunisation and who were on the practice's children's safeguarding register. However, there was scope to improve the follow up of children who had been identified to the practice by Child Health Cambridge as not receiving their immunisations. Child Health Cambridge is the organisation which has oversight of children who have not attended for their immunisations in the Cambridge area.

A monthly safeguarding meeting was planned to share information about any known children at risk in order to provide a co-ordinated response to their care. The practice had contacted local health visitors, midwives and school nurses, all of whom were due to attend with the lead GP. The first meeting was planned for the 14 May 2015.

There was a chaperone policy, and notices advising patients of this service were visible in 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). We were told by the deputy practice manager that non-clinical staff who had not had a Disclosure and Barring service (DBS) were no longer acting as chaperones until they had had a DBS check. The staff we spoke with confirmed this. We found that chaperones had received training on their role. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We noted the arrangements in place for patients to order repeat prescriptions. Patients we spoke with told us they received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. There was a process in place issuing repeat prescriptions. These were passed to the GP for electronic prescribing. For patients whose repeat prescription request identified that they were due for review, the prescription clerk sent a task to the GP to review the medicines, which included inviting patients to attend for a medicine review. We saw that prescriptions for controlled drugs were not issued electronically but were issued in hard copy and were manually signed by a GP. This was to ensure increased safety and monitoring of supply. There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken by practice staff based on the results.

The practice had one GP bag which contained medicines. This bag was checked weekly to ensure that medicines were within their expiry date and suitable for use. Records of these checks were documented. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery. The practice did not hold any controlled drugs.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The cleaning of the practice was undertaken by an external cleaning company. We saw that cleaning schedules were place, which included the cleaning of clinical equipment by the practice nurse. However, there was no documented check that these were undertaken. The deputy practice manager informed us that they spoke with the cleaning company weekly to discuss any issues with the cleaning. They also informed us that they did weekly checks of the cleaning but that they did not document this. During the inspection the deputy practice manager informed us that they had spoken with the cleaning company and had agreed that a record of the cleaning would be kept by the company from here on and they advised that they would document the spots checks of the cleaning.

The practice had a lead nurse responsible for infection control who had undertaken further training in infection control. We looked at four staff files and found that staff had all completed infection control training. The most recent infection control audit was completed in August 2014. We saw that actions had been identified and completed. For example a chair in the waiting room which had been ripped, had been disposed of. The actions from the infection control audit were discussed at the monthly clinical meeting.

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 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 liquid soap, hand gel and paper towel dispensers were available in treatment rooms.

The deputy practice manager told us that the landlord of the building had undertaken a legionella risk assessment in November 2014. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that regular checks were carried out in line with the risk assessment to reduce the risk of infection to staff and patients.

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 serviced 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 which was November 2014. We saw the certificate of medical equipment calibration which had been completed in December 2014. This included for example, weighing scales and blood pressure measuring devices. We noted that the date when re-testing was due was recorded on the risk log for the practice.

Staffing and recruitment

The practice had a recruitment policy and procedure that set out the standards it followed when recruiting clinical and non-clinical staff. 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). We saw that regular checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty. Staff told us there were enough staff to maintain the smooth running of the practice and there were enough staff on duty to keep patients safe. There was an arrangement in place for members of reception staff to cover each other's annual leave. We were told that cover for GPs, nurses and the health care assistant was provided by locum GPs and nurses who had worked at the practice before. We saw evidence that where annual leave had been booked by a clinician, cover by a locum clinician had already been arranged. The practice manager showed us records to demonstrate that 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 medicines management, staffing, dealing with emergencies, equipment and six monthly health and safety environmental audits. The practice also had a health and safety policy and there was an identified health and safety lead. There was a planned maintenance schedule which included for example, fire checks, legionella checks and gas boiler checks. A risk assessment had been completed in January 2015 for the cleaning of the surgery by an external cleaning company. This identified areas of risk including for example, chemicals, lone working and manual handling and actions to be taken to reduce the risks.

Identified risks were included on a risk log. We saw that each risk was described, with the likelihood of it happening, actions which needed to be taken, by whom and by when, with a date for review and when the action had been completed. The risk log was emailed to the provider's head office on a weekly basis and feedback was provided to the practice. We saw that any newly identified risks, including risks to patients, significant events, complaints or infection control were discussed at the monthly clinical meetings.

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 and anaphylaxis, appropriate to their role. 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

Good

Are services safe?

knew the location of this equipment and records confirmed that it was checked weekly. Emergency medicines were available in a secure area of the practice and included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Staff we spoke with knew of their location. Processes were also in place to check whether emergency medicines were available and within their expiry date and suitable for use. There were weekly checks which confirmed that this happened. 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 might impact on the daily operation of the practice. We noted that this had been due for review in February 2014 and therefore was out of date at the time of our inspection. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of building, power failure, loss of the computer system, incapacity of GPs and loss of the telephone system. The document also contained relevant contact details for staff to refer to. A copy had been emailed to all staff and copies of the business continuity plan were kept off site.

The practice had a fire safety policy and had carried out a fire risk assessment that included actions required to maintain fire safety. We saw records of regular checks of the fire equipment, fire alarm and emergency lighting. We saw evidence of a practice fire drill which had been competed in December 2014, which had been successful. Records showed that all staff were up to date with fire training. There were identified members of staff who had completed training to be a fire marshal.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their 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. We saw minutes of monthly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. 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 GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Patients told us that they were reviewed regularly for their long term conditions.

National and local data showed that the practice was in line with referral rates to secondary and other community care services. All GPs we spoke with used national standards for patients with suspected cancers to be referred and seen within two weeks. There was external clinical review of referrals and the GPs considered feedback and took appropriate action. We looked at the clinical meeting minutes and saw evidence of review of referrals which had been made by a locum GP.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. There was a protocol for repeat prescribing which was in line with national guidance. We saw evidence that patients had received a timely medication review. We saw evidence of effective monitoring of patients who were prescribed potentially toxic medicines, where monitoring of their blood or urine was required. The patients we spoke with confirmed that their medicines were reviewed regularly.

The practice showed us a number of clinical audits that had been undertaken. One clinical audit related to the number of patients who were prescribed antibiotics, outside of the Clinical Commissioning Group (CCG) guidelines. Antibiotic prescribing guidance was identified and shared and the audit was repeated. There was no reduction in the number of patients who had been prescribed an antibiotic outside of the CCG guidance. However, the clinicians were able to gain insight into why specific antibiotics had been prescribed and were able to justify the clinical reasons for this, for example, patients' allergy or frailty. Another clinical audit related to a medicine for Type 2 diabetes and whether it was being prescribed according to National Institute for Health and Care Excellence (NICE) guidelines. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. The re-audit showed that all patients where this medication had been initiated by a GP at the practice were being treated according to the NICE guidelines. Two patients were identified who had had this medicine initiated at the hospital diabetic clinic. We saw that the practice had written to the hospital to ask for justification for the treatment.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (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 practice had a total achievement of 93.7%. We noted that the practice scored above the Clinical Commissioning Group (CCG) and England average for mental health, dementia, depression and learning disability.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

All new staff underwent a period of induction when they first started to work at the practice. Files we checked, and staff we spoke with confirmed this to be the case and staff told us they found it a useful introduction to their role.

The practice staff included medical, nursing, managerial and administrative staff. We reviewed four staff files and saw that all staff were up to date with attending training deemed mandatory by the provider, such as basic life support, safeguarding and health and safety. The Practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

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

The practice had an appraisal policy and process in place for its staff, which included agreeing a personal development plan as part of the appraisal process. We looked at six staff files which showed that five staff had received both an annual appraisal and a personal development plan. However one member of staff did not have a personal development plan.

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. Patient correspondence was passed to the lead GP to action. We were told that this was actioned the same day and we noted there was no outstanding patient correspondence on the computer system for action by the lead GP. We were told that the prescribing clerk would review hospital discharge summaries and if there were any changes to patients' medicines, they would inform the GP.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract.) The GP contacted each patient within three days of them being discharged from hospital in order to follow up on their care and treatment.

We were told by the deputy practice manager that the practice held multidisciplinary team meetings on a monthly basis to discuss patients with complex needs. This included for example those patients who had had deterioration in health and patients who had been discharged from hospital. The practice had a palliative care register and the care and support needs of patients and their families were also discussed at this meeting. The meetings were organised by a multi-disciplinary team coordinator who organised appropriate professionals to attend the meeting. We were told that these were usually attended by district nurses, social workers, palliative care nurses, a community physiotherapist and a GP. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used the Choose and Book system for making referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in patients' care and treatment. We saw evidence that referrals were made in a timely way.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

Good

Are services effective?

(for example, treatment is effective)

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 saw that the practice had a consent policy and consent forms. We were told that verbal consent was recorded in patient notes where appropriate. Patients we spoke with, and received comments from, confirmed that their consent was obtained before they received care and treatment.

Clinicians spoken with demonstrated an understanding of legal requirements when treating children. The practice nurse confirmed consent was always obtained from parents prior to immunisations being given and gave examples of when they would not proceed with an immunisation if parental consent could not be obtained. The clinical staff we spoke with demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.)

We found that the majority of clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The practice had Mental Capacity Act guidance available for staff and the GPs used the Royal College of GPs toolkit when making decisions in relation to a patient's mental capacity. The majority of 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.

All staff were aware of patients who needed support from nominated carers, and clinicians ensured that carers' views were listened to as appropriate.

Health promotion and prevention

There was a large range of up to date health promotion information available at the practice and on the practice website, with information to promote good physical and mental health and lifestyle choices. The practice website referred patients to a range of information supplied by Patient.co.uk. This included information on children's health, women's health, men's health, mental health, sexual health, health promotion and immunisation. We noted that information was clearly signposted so that patients could easily identify where specific information could be found.

New patients who requested to register at the practice were asked information to find out details of their past medical and family health history, their lifestyle and medicines. The locality manager advised that all patients should also be offered a health check which was undertaken by a nurse or a health care assistant. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP in a timely manner. The practice offered NHS Health Checks to all its patients aged 40-75 and these were undertaken by a nurse or health care assistant.

The practice offered smoking cessation support to patients and they undertook initial assessments and referrals, if appropriate to the 'Weigh to go' weight management programme. Weekly health walks were organised by a past member of the patient participation group and these were open to all patients. Notices were available in each of the consultation and clinical rooms, in the waiting area and in the patients toilets informing patients that chlamydia screening was available to patients aged 18 to 25 years.

The practice had numerous ways of identifying patients who needed additional support. The practice kept a register of all patients with a learning disability and offered them an annual health check. On the day of our inspection, we were told that seven of the 13 patients with a learning disability (54%) had attended for an annual health check. There was scope to improve the follow up of patients with a learning disability who did not attend for their annual health check.

We looked at the most recent Quality and Outcomes Framework (QOF) data and noted that the practice had scored higher than the Clinical Commissioning Group (CCG) and England average for cervical screening, primary prevention of cardiovascular disease and child health surveillance. Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. We saw that this information was available in a number of different languages, although it was kept behind the reception desk. We spoke with the practice management team about this and they advised they would move it so that it could be easily accessed by patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a person centred culture and staff and management were committed to working in partnership with patients. During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. We spoke with seven patients and reviewed six CQC comment cards which had been completed by patients to tell us what they thought about the practice. Patients told us that staff were caring, they were treated with respect and their privacy was maintained.

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 and clinical room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception was located in the waiting room area. There was a notice asking patients to respect other patients' privacy and staff we spoke with told us that they would support patients to a private room if they were upset or if they were sharing sensitive information. However there was no notice informing patients that they could request this. We spoke with the provider about this. We were sent photographic evidence the day after the inspection which showed that notices were now displayed informing patients of this.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. 279 surveys had been sent out with 119 being returned, which was a response rate of 43%. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (63%) and for whether nurses listened to them, 67% reported this as being good. Satisfaction rates for patients who thought they were treated with care and concern by their GP was 80% and for whether the GP listened to them, 85% reported this as being good. 72% of respondents described their overall experience of the practice as good and 56% of patients stated they would recommend the practice. These results were below average when compared with other practices in the CCG area. The practice were aware of the low results and had an action plan in place to improve customer service and patient satisfaction. This included for example some clinicians having a 'softer' approach in their consultations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that 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 and did not feel rushed. Patient feedback on the comment cards we received was also positive and aligned with these views.

Data from the national GP patient survey, published on 8 January 2015, showed 70% of practice respondents said the GP involved them in care decisions, 74% felt the GP was good at explaining tests and treatments and 78% said the GP was good at giving them time. In relation to nurses: 54% said they were good at involving them in care decisions; 62% felt they were good at explaining tests and treatments and 67% said they were good at giving them enough time. These results were below average when compared with other practices in the Clinical Commissioning Group (CCG) area. The practice were aware of the low results and had an action plan in place to improve customer service and patient satisfaction.

Patient/carer support to cope emotionally with care and treatment

When a new patient registered at the practice they were asked if they were a carer and offered appropriate support. The practice identified patients who were carers on the computer system so staff and clinicians were automatically alerted to patients who were also carers. This ensured that the practice staff were aware of the wider context of the patients' health needs. Information for carers was available in the waiting room.

Staff at the practice told us that if families had suffered bereavement, they routinely sent a letter to the bereaved family members. We saw that information was available in

Good

Are services caring?

the waiting area which signposted patients to local bereavement support. We were told by the lead GP that patients were referred for bereavement counselling if this was appropriate.

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 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 practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs.

There had been little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them, which included patients with long term conditions or those who needed to use an interpreter. Home visits were available to patients who could not attend the practice. Patients had access to both a male and female GP, however seeing a GP of choice was not always possible for urgent appointments.

The practice used to have a patient participation group (PPG) which met monthly. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. The PPG was disbanded in November 2014. We spoke with three representatives from the PPG who confirmed that the practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. For example moving a notice board away from a consultation room where consultations might be overheard. They also commented positively that the practice had expanded the hours that they provide a service to patients.

Patients we spoke with on the day of our inspection told us they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this.

Tackling inequity and promoting equality

The practice had an equality and diversity policy and provided equality and diversity training, which the majority of staff had completed. The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. Staff told us that translation services were available for patients who did not have English as a first language. Information was available on the practice website informing patents this service was available. However we did not see any notices in the waiting area. We spoke with the provider who said they would ensure this information was provided. Longer appointments were available for patients who needed them, including those who needed an interpreter. There was a self check in screen which could be accessed in four different languages.

The practice was situated in a single level building. At the front of the practice, there was a ramp and handrails to support independent access to those patients with mobility needs and those who used prams. At the back of the practice there were automatic doors. However at both entrances there were also fixed doors with no means of patients who needed support to access the practice staff to obtain help. The locality manager told us that they had previously raised this with the landlord but no improvements had been agreed. The day after the inspection we were provided with photographic evidence that notices had been put on the doors advising patients who needed support to access the practice to knock on the door and staff would come and assist.

The waiting area was large enough to accommodate patients with wheelchairs and prams. There was easy access for people with mobility needs, to all the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice opened every week day between the hours of 7:00am and 6:30pm, Monday, Wednesday and Thursday and between 08:30am and 6:30pm on Tuesday and Friday. Early morning appointments were available Monday, Wednesdays and Thursdays which was particularly useful to patients with work commitments.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments, telephone consultations and home visits. Appointments could be booked by telephone, in person or online. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015 and found that

Good

Are services responsive to people's needs?

(for example, to feedback?)

75% of patients described their experience of making an appointment as good and 90% said the last appointment they got was convenient. These results were in line with other practices in the Clinical Commissioning Group. Comments received from patients on the day of the inspection showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. They confirmed that they could see another doctor if there was a wait to see the doctor of their choice. We noted that routine appointments with clinicians were available in nine to fourteen days time.

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.

Information about the complaints procedure was on display in the waiting room, in the practice leaflet (which was handed out to new patients) and on the practice website. There was no written complaints information given to existing patients when they advised the practice they wanted to complain, they were only provided with a complaints form. We spoke with the area manager about this, who advised that Malling Health (UK) Ltd were looking at developing a complaints information leaflet which could be used at the practice. We also noted that patients who had complained had not been advised of how to escalate their complaint to the Parliamentary Health Service Ombudsman (PHSO) if they were dissatisfied. Although this information was in the practice leaflet, this was only given to new patients and was kept behind reception. This meant it was not freely available to patients. The practice provided photographic evidence the day after the inspection, that information on how to escalate complaints to the PHSO was on display in the practice waiting room.

We looked at three complaints received in the last twelve months. Two of these had been acknowledged, investigated and a response had been sent to the complainant. One of the complaints we looked at had been acknowledged but not been closed. The deputy practice manager told us that this is because it had been dealt with by meeting with the patient. However there was no written evidence to support this. They agreed that this should have been in place. We saw evidence that complaints had been dealt with in a timely way and an apology had been given where this was appropriate.

The practice discussed and reviewed complaints at the monthly clinical meetings in order to identify areas for improvement and share learning. These were also sent to head office for review and any additional learning was shared with the practice.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a vision to ensure patients received high quality personal care and set out their aims and objectives in order to achieve this. This included for example, to provide high standards of medical care, to be dedicated to its patients' needs and to regard all patients and staff with dignity, respect and honesty. This was documented in the statement of purpose for the practice. We found evidence of this during the inspection.

Governance Arrangements

There were clearly identified areas of lead responsibility for areas such as health and safety, infection control, child safeguarding and adult safeguarding, complaints, clinical governance and data protection. We spoke with eight members of staff who were clear about their own roles and responsibilities. The majority of staff told us they felt valued and supported. They all reported knowing who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern its activity and these were available to staff within the practice. We looked at 16 policies and procedures and found the majority were in date. However, we noted that there were some gaps where the policy had been created corporately and not adapted to Maple Surgery. Policies and procedures were kept in hard copy and also electronically and could be accessed by staff on the shared drive. However we noted that not all policies could be easily found electronically. Staff we spoke with knew where to find hard copies of the policies if required.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential hazards. This was updated weekly and sent to the area manager and then to head office. Risk assessments had been carried out where risks had been identified and action plans had been produced and implemented. For example there was a completed risk assessment for the work which was undertaken by the external cleaning company.

We looked at minutes of the monthly clinical meetings since September 2013 and found that performance, quality and risks had been discussed. For example, we saw that QOF data was discussed at monthly clinical meetings and action agreed to maintain or improve outcomes. The practice used the Quality and Outcomes Framework (QOF) to measure its performance and it was performing in line with national and local standards.

Leadership, openness and transparency

There was effective leadership at the practice, which was divided into clinical and managerial leadership. We saw effective liaison between clinicians and management and there was a shared understanding of each other's roles. Monthly clinical meetings were held and administration meetings every two months. The reception staff and deputy practice manager were located in close proximity so information was shared regularly on an ad hoc basis too.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues when required or at meetings. During our inspection we saw that staff were comfortable seeking advice and support from the lead GP and managerial team.

The practice had a whistleblowing policy which was available to all staff in hard copy in the policies and procedure file. The staff we spoke were aware of this.

Seeking and acting on feedback from patients, public and staff

Feedback from patients had been obtained through patient surveys, the friends and family test and complaints. Patients were encouraged to feedback their views and information was provided on the practice website, in the practice leaflet and at the practice on ways to do this. We found evidence that the practice listened and responded in a timely way to formal and informal feedback.

We reviewed the most recent patient survey, which was undertaken from 10 July to 19 August 2014, to which 96 patients had responded. 75% of patients reported that they would recommend the practice to a friend or family. The practice reflected on the results and concluded that they were working well in the majority of areas. There was some concern with the number of patients (20%) who stated that they had confidence in the nurse or GP 'to some extent'. There was an action plan in place to improve patient satisfaction. This included for example some clinicians having a 'softer' approach in their consultations.

The practice used to have a patient participation group (PPG) which met monthly. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. The PPG was disbanded

Are services well-led?

Good

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

in November 2014. We spoke with three representatives from the PPG who told us that they felt the PPG had come to its natural end. They said that Maple Surgery had responded to suggestions they made, for example improving the layout of the waiting room to make it more friendly and moving a notice board away from a consultation room where consultations may be overheard. The PPG had held health awareness sessions and Maple Surgery had supported one on healthy living, healthier life which was held in June 2014.

The practice collated feedback from patients from the 'friends and family' test, which ask patients, 'Would you recommend this service to friends and family?' The friends and family feedback form was easily accessible in the waiting room for patients to complete. We were provided with the following data from the practice. 18 cards had been returned in January 2015, with 44% of patients saying they would recommend, for February, five cards were returned with 80% recommending and for March, 9 cards were returned and 77% would recommend. The practice were planning to increase the response rate by collecting friends and family feedback via text messaging.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would 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.

Management lead through learning and improvement

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. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Completed audit cycles showed that changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment. The results of patient surveys were also used to improve the quality of services.

All significant events, complaints and the risk register were regularly sent to the provider's head office. These were reviewed by the management team and any additional learning was shared not only with the practice but also with other practices which the area manager was responsible for. Maple Surgery also received information from learning from events that had occurred in other practices so processes could be put in place to minimise the risk of occurrence.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We noted that the practice nurse was being supported to undertake a non-medical prescribing course. Staff at the practice attended networking meetings outside of the practice. For example the deputy practice manager met with other practice managers on a regular basis. We looked at six staff files and saw that regular appraisals took place.