Dr Kathleen Ring

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr K Ring on 23 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, safe, caring and responsive services. It was also good for providing services for all the population groups.

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. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

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. 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 received regular performance reviews.

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. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, avoiding unplanned admissions and had met the target of having care plans for 2% of the patient population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. For example the practice made telephone calls to all older people to offer the seasonal flu vaccination and the GP carried out home visits to all older patients who were unable to attend the practice to receive it.

The practice offered support and signposting advice for services such as making blue badge applications, benefit applications and dial a ride services. The practice had good links with other providers to ensure the needs of older people were met.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments were offered to patients with long term conditions. The healthcare assistant and nurse provided the baseline monitoring for most patients however the GP saw the diabetic patients for their annual review so that all aspects of their care needs could be co-ordinated. The GP also undertook the annual foot check and the prescribing review for diabetic patients and worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Patients with long-term conditions such as rheumatoid arthritis, heart disease, Parkinson's disease, kidney disease and dementia were also reviewed annually.

Seasonal flu and pneumococcal vaccinations were offered annually.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Summary of findings

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, health visitors and school nurses.

Pre-natal and antenatal care was provided to pregnant woman and women who had recently given birth. The practice ran a Children's clinic which included delivering the immunisation programme.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online appointment booking and medication requests as well as a full range of health promotion and screening that reflects the needs for this age group. Extended hours were available on Monday evenings.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

There were six patients on the learning disabilities register and the practice had carried out annual health checks for them all. They also offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). There were 14 patients on the mental health register and 100% had received an annual physical health check, blood pressure check, alcohol status recorded and where relevant a smear test recorded.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations in the community. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 41 completed CQC comment cards and spoke with five patients during the inspection. Generally patients were happy with the service they received. Patients described staff as helpful and caring and providing an excellent service. They were all complimentary about staff and the care they received.

Patients commented that having a single handed GP was a good thing because they were guaranteed continuity of care and they GP was knowledgeable about their medical history. Patients we spoke with generally felt it was not difficult getting through to the practice on the phone. Patients generally felt that waiting times were appropriate and they hardly had to wait excessively long.

Dr Kathleen Ring

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 advisor and a second inspector from the CQC. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr Kathleen Ring

The Crescent Surgery provides GP primary medical services to approximately 2372 patients living in the London Borough of Bromley. Demography of people using the service aged 50-74 are above both the England and CCG averages for female patients. Rates for male patients were broadly in line with both England and the CCG averages except for the number of male patients aged 65-69, which was higher than both averages.

The practice facilities include two consulting rooms, induction loop, wheelchair access, step-free access, a disabled WC, type talk and signing service.

Dr Ring is a single handed GP. Other practice staff include a nurse practitioner, healthcare assistant, and a secretary and reception staff. The practice holds a general medical services (GMS) Contract. A GMS contract is a contract between general practices and NHS England for delivering primary care services to local communities.

The practice has opted out of providing out of hours (OOH) services to their patients. If patients required advice or assistance out of hours they were directed to the'111' service for healthcare advice.

The practice is registered with the Care Quality Commission to provide the regulated activities of doctors' consultation service, treatment of disease, disorder or injury, diagnostic and screening procedures and maternity and midwifery services.

The practice opening hours are between 8am to 6.30pm Monday to Fridays. GP appointments are available between 8-11am and 4-6.12pm. The practice offer extended hours on Mondays between 6.30pm to 7.10pm. Although the practice do not have a website they offer online appointments, repeat prescription, test results and access to medical record facilities through a generic website for all NHS patients. Home visits were available for housebound, elderly and frail patients and any other patients who were unable to attend the practice.

The practice provides a range of services including an asthma clinic, child health and development clinic and long–acting reversible contraception.

Why we carried out this inspection

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

How we carried out this inspection

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

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice, including information published on the NHS Choices website and the national patient survey 2014. We asked other organisations including NHS England and the Clinical Commissioning Group (CCG) to share what they knew about the practice.

We carried out an announced visit on 25 February 2015. During our visit we spoke with a range of staff including the GP (also the registered manager), nurse practitioner and administration staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 significant incidents, national patient safety alerts and safeguarding information. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and alert the lead GP. For example, we were told that the practice experienced a power outage in December 2014, and had to ensure that measures were taken to allow continuity of the service for patients and staff by having direct contact with a neighbouring practice to provide information from patient electronic records.

We reviewed the significant incident folder, incident book and minutes of meetings where incidents had been recorded over the last three years. Although there had been a low number of incidents, this showed the practice had managed these consistently over time 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. We saw the significant events policy that had been recently updated. There were records of significant events that had occurred during the last three years and we were able to review these. We were provided with evidence of one significant event analysis within the last year. For example, where the practice experienced a power outage in December 2014 and staff were unable to access electronic patient records, patients were informed of the incident and a neighbouring practice were able to access the necessary patient records to allow safe consultations to go ahead. All staff were made aware of this solution for the future if the power outage were to reoccur. The practice also shared the learning from this incident with neighbouring practices. We saw that the practice used a communications folder where staff had to sign to record that they had read the significant event.

One member of staff we spoke with discussed an incident where one of the clinical rooms had been flooded and alternative arrangements had to be made to ensure patients remained safe and the consultations could run as planned. This was recorded in the incident book, however we could not find documentation that a significant event analysis was carried out following this incident and there was no evidence that the incident had been discussed and shared with other practice staff.

Significant events was not always a standing item on the practice meeting agenda as the practice had alternative arrangements in place due to difficulties with arranging staff meetings. We saw that the practice regularly used a communications folder so where significant events occur, learning outcomes can be shared with staff. The folder was updated every month with new information. Staff we spoke with were familiar with this system and they felt it worked well for the practice.

National patient safety alerts were disseminated by the lead GP to practice staff. We saw the process for handling safety alerts, where all the alerts were read, signed and actioned by the GP and the information was cascaded to staff where needed, by being placed in the communications folder. The alerts were also all stored in the safety alert folder, which was accessible to all staff. An example of a recent safety alert included an eye ointment recall notification.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. All clinical staff were trained to level three for child protection and safeguarding adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff we spoke with 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 for the local authority safeguarding teams and the CCG safeguarding lead were easily accessible and staff showed us where to find these details in the reception area.

The GP had been appointed as the lead for safeguarding vulnerable adults and children for the practice team. The GP discussed a situation where a safeguarding referral had been made and the practice worked with a number of

organisations including the police in relation to this incident. We saw that this had been discussed with all staff via staff meeting minutes, and safeguarding updates were a regular feature when staff meetings occurred. Staff we spoke with were aware the process for reporting concerns to the lead GP if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and adults at risk. We saw how the electronic system flagged up patients coded as vulnerable. The GP was the lead for coding all patients that were vulnerable. The practice regularly discussed child protection issues with the health visitor who attended the practice monthly. We were told that in instances where patients fail to attend for childhood immunisations, the lead GP investigates and will either make arrangements directly or ask reception staff to invite the patient into the practice. The GP would also inform the health visitor of any concerns.

The practice had some arrangements in place for chaperoning; however a chaperone policy was not in place. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).Chaperone signs were visible in the waiting room. The GP told us that only the practice nurse would act as a chaperone if required and the reception staff would not be asked act as a chaperone. Reception staff also told us they did not act as chaperones. As there are no male GP's at the practice, we were told that in instances where patients needed a prostate examination, the GP would call the patient in advance and advise them they could bring a family member to act as a chaperone if required.

Medicines management

The practice held a stock of vaccines and medication to administer in the event of an emergency. 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, which described the action to take in the event of a potential failure. The practice staff followed the policy. We saw that the vaccine fridge was locked, was located in a locked room and was appropriately stocked. A flow chart was on view for staff to follow when monitoring fridge temperatures. Temperatures were recorded once daily using the fridge thermometer and an external fridge thermometer was also available. We saw that storage of medication was a standard item on the practice's work place risk assessment.

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

All prescriptions were reviewed and signed by the GP before they were given to the patient. Repeat prescriptions were kept inside the manned reception area before and after being signed by the GP. We saw that blank prescription forms were kept inside the staff reception area, and when the desk was unmanned, the reception office door was locked. Some prescription forms were kept in drawers in the GP room but these doors were locked when the GP was not present. We were told that the GP kept a record of all the invoice numbers of deliveries of blank prescription forms.

The practice did not hold and controlled drugs on the premises.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place detailing the weekly, monthly and quarterly cleaning tasks. Cleaning records were kept for the monthly and quarterly cleans but cleaning records were not updated daily. We saw that the practice had an up to date COSHH register (control of substances hazardous to health). There were safety data sheets available for each product used. We were told that any items containing bleach were stored away from the main practice area. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The GP was the lead for infection control. All staff had received training for infection control. Clinical staff had received yearly updates. The practice reviewed infection control internally as part of a yearly work place health and safety risk assessment, but did not complete separate internal infection control audits. The practice had invited Public Health Bromley infection control lead to carry out external audits for each of the last two years. Staff in the

practice took part in these audit. Most improvements identified for action were completed on time. For example, it was identified that the practice needed to purchase disposable ear pieces for measuring temperature and disposable mouth pieces for measuring peak flow (a breathing test). The practice had completed this action by the last audit in January 2015. An action that was on-going was to ensure hand wash basins were updated to meet national standards during the next refurbishment. The practice was maintaining an on-going risk assessment for this. Minutes of practice meetings showed that the findings of the audits were discussed. The practice also shared the health and safety risk assessment and infection control audit findings with all staff, using their staff communications folder.

Personal protective equipment including disposable gloves were available for staff to use. The practice had readily available sharps containers in clinical rooms which were appropriately located. Clinical waste and sharps were collected once every week. The practice had a needle stick policy and procedure in place. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap and hand towel dispensers were available in treatment rooms.

The practice had completed a risk assessment in line with HSE guidance, in relation to the management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw evidence that the practice had carried out this risk assessment in 2013. The risk assessment confirmed that the practice did not need to test for legionella as there was no stored water in the premises and water was not thermostatically controlled.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw 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. The practice underwent a full electrical review in February 2015 and all remedial works necessary had been completed. We saw an electrical installation certificate that confirmed this. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, a nebuliser and the fridge thermometers.

Staffing and recruitment

There was a comprehensive recruitment policy in place for the practice. This policy had been shared with all staff and was visible in the staff communications folder. Records we looked at for staff that had been recently employed 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 induction checklists had been completed for new members of staff.

We were told that the practice also kept records for a sessional staff member who was not directly employed by 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 rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts. There was a regular locum GP who was used to cover the GPs sessions when they were away and also during busy times, such as when the GP planned longer appointments to carry out patients reviews. Patients we spoke with told us that it was useful to have a regular locum because it was a GP they were familiar with and it ensured continuity of care. The business manager showed us the workforce overview to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Sessional staff were used dependent on needs of the service. For example, a sessional GP, a sessional practice nurse for specific clinics and a locum business manager.

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 an annual Health and Safety Risk Assessment completed by the lead GP which

included fire arrangements, infection control, storage of medications, COSHH, equipment and the environment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see and there was an identified health and safety representative.

We saw that outcomes from the risk assessment were also discussed at the practice meetings as well as being shared more regularly with staff via the communications folder system. For example, recent staff meeting minutes detailed the updated COSHH folder as a result of the health and safety risk assessment. There were also clear, documented action points and a plan in the staff meeting minutes, following a fire alarm test and evacuation procedure.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Training records showed that all staff had received training in basic life support, and this was updated yearly for clinical staff and 2 yearly for non-clinical staff. Some emergency equipment was available including 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. Oxygen was not available at the practice for medical emergencies. Staff told us that this was due to restrictions imposed by the local authority planning office. They told us that oxygen was available on neighbouring premises and they had arrangements in place to use it if they needed to. There had not been any medical emergencies for the practice to record over the last few years.

A stock of emergency medicines was 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. The anaphylaxis pack was checked every 3 months.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The practice had a working example where they had to refer to the Business Continuity Plan due to a power outage in December 2014. The action plan was commenced to ensure the service could safely continue with consultations and the action plan for this particular risk was amended in the Business Continuity Plan following learning from this incident.

The practice had carried out a fire risk assessment by an external contractor in 2012 that included actions required to maintain fire safety. The practice carried out internal fire risk assessments yearly as part of the health and safety risk assessment for the practice. Records showed that staff were up to date with fire training and that they practised regular fire drills. We saw a detailed action plan following a fire evacuation procedure and learning from this exercise. For example, the fire plan was altered to ensure that windows were closed before evacuation and the practice also had an action to update emergency contact numbers for personnel, in the fire procedure. Fire extinguishers were checked yearly to ensure they were fit for purpose and we saw evidence to confirm this had taken place.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse we spoke with clearly outlined 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. For example the GP showed us how they used the local CCG intranet to follow referral guidelines. The practice followed antibiotic guidelines from Kings College and the two week referrals guidelines for suspected cancer. Our discussions with the GP evidenced that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice had taken part in a remote monitoring programme for hypertension where patients were asked to use their mobile phone to input their blood pressure in the morning and evening recordings into software. This was to help identify new cases of hypertension.

The GP told us they led in all specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse and health care assistance supported this work. Staff confirmed that the GP provided them with support and guidance.

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

Management, monitoring and improving outcomes for people

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

The GP showed us three clinical audits that had been undertaken in the last year. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The audit was for cytology and had been completed annually over the last three years. Results of smears were audited to identify both inadequate smears and any missing results. There were 164 in total with three missing results. The outcome of the audit concluded that the method and process for smear taking returned was satisfactory and no further action was needed. Other examples included a clinical audit on effective time management to try and minimise consultations over-running and an audit on atrial fibrillation prevalence rates.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (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, 100% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

There was a protocol for repeat prescribing which was in line with national guidance. We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GP 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 GP had oversight and a good understanding of best treatment for each patient's needs.

There were 38 patients on the practice risk register. All of these patients had a care plan in place which had been reviewed within the last month. The GP told us that each patient was given a one hour appointment for the completion of their care plan and review. As it was a single handed GP a sessional GP was used to ensure patients still had access to a GP.

Good

Are services effective?

(for example, treatment is effective)

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as quarterly multidisciplinary meetings to discuss the care and support needs of patients and their families. Staff told us that they discussed all patients on the register, patients likely to go on the register and patients recently deceased to ensure lessons learnt were identified and discussed.

Effective staffing

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

The practice nurse was a nurse prescriber and was the person who led on the baby and children's' clinic and travel vaccinations. The health care assistant led on new patient checks, vascular checks and long-term conditions checks. The GP told us that as the practice was small the care of patients with COPD was outsourced to a GP practice nearby to ensure patients received specialised care.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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 practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP was responsible for any action that was required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for taking action with hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and 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. The health visitor also made weekly visits to the practice.

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 (the 111 service) to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 585 referrals last year through the Choose and Book system. (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). Staff reported that this system was easy to use.

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

Good

Are services effective?

(for example, treatment is effective)

electronic Summary Care Records and had signed up to it following the pilot. (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 had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. We spoke the GP and the nurse and they both understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had a policy for staff to follow if a patient lacked capacity. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example there were 17 patients on the dementia register and all of them had a care plan in place which had been reviewed within the last 12 months. We saw that they were involved and supported to make decisions. When interviewed, the GP gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. Lifestyle choices and details relating to smoking status were taken. The GP was informed of all health concerns detected and these were followed up in a timely way. The health care assistant was also responsible for carrying out the vascular checks and weight management

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that over the past 12 months 669 patients were eligible for the check and 208 patients were invited. Of the 208 invited, 197 had taken up the offer of the health check. The GP showed us how patients were followed up and scheduled further investigations if risk factors for disease were identified.

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 all patients with a learning disability and all six were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months. Smoking cessation sessions were offered to patients. The practice had identified 144 male and 122 female patients as smokers (266). Support had been offered to 269 of these patients. A total of five patients had stopped smoking in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 91%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. Performance for bowel cancer screening in the area was in line with the CCG average. Over the past 12 months 186 patients were eligible for bowel cancer screening and all 186 had been sent home testing kits. Of these 100 patients (54%) had responded and returned the kits. Two patients were found to have abnormal test results and were sent for screening.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Last year's performance for children's' immunisations was above average for the CCG. There were 26 children aged 12 months and eligible for Dtap/IPV/Hib, Men C, PCV and 100% of children eligible had received the vaccinations compared to 94.7% for the CCG. There were 31 children aged five years and eligible for MMR Dose 1, Infant

Good

Are services effective?

(for example, treatment is effective)

Hib and Dt/Pol Primary and 96.8% had received the vaccinations, which was all above the CCG average. There was a clear policy for following up non-attenders which included calling parents if they did not attend for an appointment.

There were 457 patients aged 65 and over eligible to receive the seasonal flu vaccination and 376 had received the vaccination, 84 patients declined and 4 patients had received the vaccination from another healthcare provider. Staff told us that they proactively invited patients to attend the practice to have the vaccination and visited patients who were housebound.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey conducted in 2015 (263 surveys sent out; 123 surveys sent back; 47% completion rate) [The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England; latest results were published on 8 January 2015] The evidence from this survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 91% of patients rated the practice as good or very good (compared to the National average of 81%). The results of the survey showed that 94% of the respondents had confidence and trust in the last GP they saw or spoke to. Ninety six per cent of respondents to the national patient survey said reception staff were helpful.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 41 completed cards and all of the comments were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said all staff treated them with dignity and respect. We did not receive any negative comments. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the GP or the business manager. The GP told us they would investigate these and any learning identified would be shared with staff.

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

Care planning and involvement in decisions about care and treatment

The national patient survey results 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 88% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were above the CCG average 72 and 79% respectively.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

We saw that patients with conditions such as dementia, learning disabilities and mental health problems had care plans in place and were involved in their care planning.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received indicated that

Good

Are services caring?

patients felt supported to cope emotionally with care and treatment. For example, patients told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room 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 the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, the GP contacted them and would either visit their relatives or make an appointment (double appointment) for them to be seen in the practice if this was preferred, even if the relative was not a patient of the practice. Details of all recent deaths were kept at reception so staff were aware, for their own knowledge as well as to be informed if a family member attended the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice was in a geographical area where the travelling population regularly resided. The GP told us that travellers were registered at the practice and where relevant they encouraged them to attend for health checks and other screening services. Homeless people could also register at the practice on a temporary basis and receive a service. We were given an example of a patient who was homeless due to domestic violence. The practice had registered them temporarily and worked with the local authority and women's aid service to ensure their health needs were met until they were rehoused.

The practice maintained a list of housebound patients. They had an alert on the system so that if they contacted the practice staff were aware they were housebound. The GP carried out home visits to all housebound patients and other services were also provided. For example the practice contacted all housebound patients and offered to attend their home to administer the flu vaccination.

The nurse was an independent prescriber and led on the baby and Children's clinic. The clinics were scheduled outside of ordinary consultation times to ensure babies were protected from the risk of infection from other generally unwell patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the practice had patients from the travelling community and people fleeing domestic violence, identified their needs and provided suitable care.

The practice had access to online telephone translation services. The practice provided on-line equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training. We were told this was completed in 2011, however a refresher was planned for the coming months. We saw that equality and diversity was regularly discussed at staff appraisals and team events.

The practice was situated on one level on the ground floor of the building. The main entrance door was security control and accessible for patients in wheelchairs. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 8 .00am to 6.30pm Monday, Tuesday, Wednesday and Fridays. Appointments were available from 8.25am to 11.00am and 1.00pm to 6.30pm on these days. On Thursdays the practice was open from 8.00am-1.00pm. With the agreement of NHS England there were agreements in place for another local GP practice to provide cover from 1.00pm-6.30pm. The practice offered extended hours on Mondays from 6.30pm-7.20pm.

The practice did not have a dedicated website; however information was available for patients on the NHS Choices website. This included details about their opening times, staffing details and the practice facilities. 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 were made to patients if they were elderly or had vulnerabilities that meant it was difficult for them to visit the practice.

Patients were generally satisfied with the appointments system. They confirmed that they could see the doctor on the same day if they needed to. As it was a single handed GP there was no choice over which GP they saw, however the GP told us that if patients preferred to see a male GP this could be arranged with one of the practices they

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

The practice's extended opening hours on Mondays between 6.30pm-7.20pm was particularly useful to patients with work commitments. This was confirmed by one of the patients we spoke with.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This included a procedure, leaflet explaining how to make a complaint and a complaints form. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had not received any complaints over the past 12 months. The business manager talked us through how they would deal with a complaint in the event of receiving one. The explanations were in line with their policy.

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 clear vision to deliver high quality care and promote good outcomes for patients. The GP told us the strategy for the coming years and evidenced that plans were in place and ensure the security of the practice for the future. The practice was working with commissioners to plan the services the practice provided in the future. We saw that other agencies were involved in the planning, including NHS England.

We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff told us and us saw in meeting minutes that staff were kept fully up to date regarding plans for the future of the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a book which was kept in the reception area. We looked at five of these policies and procedures and staff we spoke with confirmed that they had read the policies were familiar with them.

There was a clear leadership from the GP and staff were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and confident to go to the GP 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 shared with staff through email updates and in the virtual team meeting folder that was used to update weekly.

Leadership, openness and transparency

The practice was a small service with a small clinical team. All the administration staff worked part-time. The GP told us that the practicality of holding monthly team meetings was not feasible. Instead the practice operated 'virtual' meetings through a communications folder where an agenda was set and information put into the folder. All staff were required to read the contents of the monthly updates and sign to confirm when they have completed this. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with the GP or the business manager.

All staff we spoke with told us they were happy with the leadership and openness of the GP. As it was a single handed practice there was only one person to go to, however staff valued this and felt that although the GP had no-one to share leadership responsibility with they were always open and transparent with staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the practice patient survey and the NHS friends and family test, comment cards, complaints and compliments. We looked at the results of the Friend and family questionnaire and saw that 77 out of 81 patients who completed the survey said they were likely to recommend the GP practice to friends or family.

The practice carried out regular surveys to collect feedback from patients. For example, we were shown a patient questionnaire carried out in March 2014 on the smoking cessation service. Patients were asked if the sessions were long enough, if staff made them feel welcome and if they received good clinical care. The results of the survey were mainly positive. We saw that the results were analysed and learning outcomes documented.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around supporting carers and people with long-term conditions and this had happened. 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 in central policies and procedures folder.

Management lead through learning and improvement

All clinical staff were up to date with maintaining their clinical professional development through training and mentoring. We looked at all three clinical staff files and saw

Are services well-led?

Good

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

that regular appraisals took place which included a personal development plan. The GP told us that the practice was very supportive of training and that they had staff training events regularly to enhance and support staff

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example a significant event involving the failure of the clinical IT system was in the December 2014 virtual team meeting minutes. Action taken and lessons learnt were outlined and all staff had signed to say they had read it.