Campingland Surgery

Quality Report

Campingland
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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We visited The Campingland Surgery on the 12 January 2015 and carried out a comprehensive inspection.

The overall rating for this practice is good. We found that the practice provided an effective, caring, responsive and well led service. Improvements were needed to ensure that the dispensary operated in a safe way.

We examined patient care across the following population groups: older people; those with long term medical conditions; mothers, 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 was friendly, caring and responsive. It addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- Patients were satisfied with the appointment system and felt they were treated with dignity, care and respect. They were involved in decisions about their care and treatment and were happy with the care that they received from the practice.
- The needs of the practice population were understood and services were offered to meet these. Feedback from the care homes where patients were registered with the practice was very positive.
- The GPs had a significant workload and were working hard to ensure patients' needs were met.

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

The provider must:

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- Improve arrangements for the safe management of medicines. The provider did not have appropriate arrangements in place for the safe supply of medicines as prescriptions were not always signed by a GP before the dispensed medicines were handed to patients.

In addition the provider should:

- Ensure the safe management of medicines for those held in GP home visit bags. The security of the dispensary should be improved to reduce the risk of unauthorised access.
- Ensure clinical staff receive safeguarding children refresher training appropriate to their role.
- Review the recruitment policy to ensure appropriate recruitment checks are undertaken prior to employment.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. The practice did not have appropriate arrangements in place for the dispensing of medicines. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to support improvement. Risks to patients who used services were not always appropriately assessed. There was no fire risk assessment in place, although regular fire drills and alarm testing were undertaken and staff had received fire safety training. Following the inspection the provider confirmed that a fire risk assessment has been completed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. 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 capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned for. The majority of staff at the practice had received an annual appraisal and dates had been booked for those staff who were overdue their appraisal. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. We also saw that staff treated patients with kindness and respect, ensuring confidentiality was maintained. Accessible information was provided to help patients understand the care available to them. Carers were identified and supported appropriately. West Norfolk Carers visited the practice every month and provided a drop in opportunity for carers.

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 the NHS England Area Team and 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 had good facilities and was

Summary of findings

well equipped to treat patients and meet their needs. There was a complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

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 leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and 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. The practice had an active patient participation group (PPG) which arranged educational events for patients which were supported by the practice. Staff had received inductions, regular performance reviews and attended staff meetings and educational events.

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. 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 in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. Home visits were undertaken in the morning to ensure sufficient time to plan care and treatment effectively.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. 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. Home visits started early in the day, to ensure that any care and treatment needed could be arranged in a timely way. The practice offered nurse led clinic appointments for a number of long term conditions, including asthma and diabetes. 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.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Patients reaching their 16th birthday were invited for a health assessment. Free chlamydia tests were easily available. The practice participated in the blue card scheme where both registered and unregistered patients could be seen by a GP for emergency contraception. We were provided with good examples of joint

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working with health visitors. Immunisation rates were relatively high for all standard childhood immunisations. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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 accessible, flexible and offered continuity of care. The practice had temporarily stopped offering extended hours appointments on a Monday evening, due to reduced capacity of GPs. This was due to be discussed at the partners away day to see how the needs of this population could continue to be met effectively. The practice offered telephone consultations as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. Nationally reported data showed the practice performed below 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 annual health checks had been completed for just over one third of patients. There was no formal process for following up patients who did not attend. We were provided with information following the inspection which showed that the practice had followed up patients and all patients with a learning disability had now received an annual health check.

The practice tended to see patients who were from the travelling community on an opportunistic basis, when they visited the practice. 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.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in

Summary of findings

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.

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 had good outcomes for people with mental health needs, including those with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

A primary care support worker attended the practice one day a week and patients could be referred by the GP. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of our inspection including two members of the patient participation group, a group of patient representatives and staff, set up for the purpose of consulting and providing feedback in order to improve quality and standards. Everyone we spoke with reported that they were treated with kindness, respect and dignity by all the staff at the practice, were provided with information about their care and treatment and involved in decisions. They also reported that they could easily get an urgent appointment and that the practice was responsive to their needs.

We spoke with representatives from two care homes, where residents were registered with the practice. We were told that patients were regularly reviewed, the staff at the practice were responsive to patient needs and the clinical care was sound.

We reviewed 29 comment cards that had been collected from patients in advance of our visit. All of the cards reported positive experiences of patients. Some of the cards referred to doctors by name, singling out individual examples of kindness, care and compassion. Two of the comments cards reported some dissatisfaction with the length of time to get a routine appointment.

Following the inspection we spoke with six patients who were registered with the practice and who had not been seen for over two years. They all confirmed that they had not accessed the practice as they had not needed to and that they had no difficulties with obtaining access to the practice.

Areas for improvement

Action the service MUST take to improve

Improve arrangements for the safe management of medicines. The provider did not have appropriate arrangements in place for the safe supply of medicines as prescriptions were not always signed by a GP before the dispensed medicines were handed to patients.

Action the service SHOULD take to improve

Ensure the safe management of medicines for those held in GP home visit bags. The security of the dispensary should be improved to reduce the risk of unauthorised access.

Ensure clinical staff receive safeguarding children refresher training appropriate to their role.

Review the recruitment policy to ensure appropriate recruitment checks are undertaken prior to employment.

Campingland 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. The team also included a practice manager specialist advisor, a second CQC inspector and a medicine management inspector.

Background to Campingland Surgery

Campingland Surgery, in the West Norfolk clinical commissioning group (CCG) area, provides a range of primary medical services to approximately 6700 registered patients living in Swaffham and the surrounding villages. According to Public Health England information, the patient population has a slightly lower than average number of patients under 18 compared to the practice average across England. It has a significantly higher proportion of patients aged over 65 and aged over 75 and a slightly higher than average number of patients aged over 85 compared to the practice average across England. Income deprivation affecting children and older people is slightly lower than the practice average across England.

There are six GP partners, three male and three female who hold financial and managerial responsibility for the practice and one salaried GP. There are four practice nurses and a health care assistant. There are also receptionists, administration staff, cleaning staff and a practice manager. There is a dispensary at the practice, led by a dispensary manager and five dispensing staff. The practice is a training practice for medical students and qualified doctors who are training to be GPs.

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

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.15am and 6.30pm, Monday to Friday with additional hours till 8pm on a Monday. Outside of practice opening hours a service is provided by another health care provider (Medicom) 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. This provider had not been inspected before and that was why we included them.

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.

Detailed findings

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 service. We spoke with representative from two care homes where patients are registered with the practice. We talked to the local clinical commissioning group (CCG), the NHS England Area Team and Healthwatch Norfolk. The information they provided was used to inform the planning of the inspection.

We carried out an announced visit on 12 January 2015. During our visit we spoke with a range of staff including GPs, nurses, dispensary, reception, administration staff and the practice manager. We spoke with two members of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We also spoke with eight patients who used the practice. We reviewed 29 comments cards where patients had shared their views and experiences of the practice. We observed how people were being cared for and reviewed the treatment records of patients. We spoke with a number of patients by telephone to obtain their views in relation to the accessibility of the service provided by 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

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. We noted that these records went back to 2005. This showed the practice had managed these consistently over time and so could evidence 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 incident forms were available on the practice intranet. Once completed these were sent to the practice manager and each significant event was also reviewed by a clinician. We saw that significant events were discussed at monthly meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We looked at the records of significant events that had occurred during the year 2013 to 2014 and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. We noted that significant events had been raised by staff in differing roles. The practice also completed an annual review of the significant events in order to identify any themes over time.

There was a process in place to disseminate Safety Alerts to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were shared at the weekly meeting to ensure all staff were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had a system in place to help ensure that patients were safeguarded against the risk of abuse. We reviewed their safeguarding adults and safeguarding children policies. Contact information for safeguarding professionals external to the practice was available. Staff had completed training for safeguarding adults. Non clinical staff had completed safeguarding children training appropriate to their role. We saw evidence that the practice was sourcing safeguarding children level three refresher training for clinical staff. Staff we spoke with had an understanding of the different types of abuse and how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a named GP appointed as lead in safeguarding vulnerable adults and children who had been trained to the appropriate level to enable them to fulfil this role. All staff we spoke with were aware who the lead GP for safeguarding was and how to escalate concerns they might have about particular patients. We reviewed minutes of meetings where staff had raised concern regarding children and vulnerable adults. We saw that information was discussed and shared with other members of the multi-disciplinary team as appropriate.

There was a system to highlight vulnerable patients on the practice's computer system. Staff we spoke with told us that this included information on specific issues so they were aware of any relevant background when patients attended appointments; for example children subject of a child protection plan.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient, including scanned copies of communications from hospitals or other services.

A chaperone policy was in place and staff we spoke with confirmed that chaperones were used. We were told by the practice manager that clinical staff acted as chaperones

and this was confirmed by the clinical staff we spoke with. We were informed by the practice manager the day after the inspection that notices were displayed advising patients of the chaperoning service available.

Medicines Management

Patients we spoke with and their representatives told us they received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. The dispensary provided a medicine delivery service for patients who lived in rural areas.

The dispensary manager told us there were regular meetings to discuss issues arising including when there were medicine-related incidents. We noted there had been few dispensing errors recorded. However, we noted that whilst policy documents relating to medicine management and dispensing practices were regularly updated and members of dispensary staff were informed of any changes, there was no written procedure for handling dispensing errors.

We noted that procedures were in place for handling written medicine changes recommended by, for example, hospital doctors when patients were discharged from hospital. However, we found that repeat medicines supplied at the dispensary were handed to patients before prescriptions were signed and authorised by the doctors. Therefore, we could not be assured that safe procedures for medicine supply were always being followed.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. However, there was scope to improve the arrangements in place for the security of medicines in the dispensary, to ensure the dispensary could only be accessed by authorised members of staff.

We noted there were arrangements in place for the regular monitoring and destruction of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Dispensing staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. We checked a sample of controlled drugs and found we could account for them in line with registered records. However, we noted that controlled drugs carried in GPs' bags were not properly recorded to account for them once they had been supplied from the dispensary.

The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. Dispensary staffing levels were in line with DSQS guidance. Records showed that all members of staff involved in the dispensing process were appropriately qualified and their competence was checked annually.

Processes were in place to check medicines were within their expiry date and suitable for use. However, we found two injectable medicines in GP home visit bags had expired and so may no longer have been safe for use. We raised this with the practice manager on the day of the inspection. Emergency medicines were held at the practice and stock levels and expiry dates were monitored appropriately. 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.

Cleanliness & 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 practice met on a monthly basis with the cleaning staff who were employed by the practice. We saw there were cleaning schedules in place and cleaning records were kept. We were told by the practice manager that regular checks of the cleaning were undertaken. Improvements could be made to ensure it was clear when cleaning had been completed and checked. We received confirmation from the practice manager following the inspection that clearer documentation of what had been cleaned and when, was now in place.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice and support to the practice on infection control. All staff received induction training about infection control specific to their role and there after regular updates. We saw evidence the lead had carried out audits every two months and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy. There was also a protocol to be followed in the event of anyone suffering a 'needle-stick' injury.

Hand hygiene techniques signage was displayed in staff and patient toilets and in the treatment and consultation rooms. Hand washing sinks were all equipped with hand wash, hand gel and hand towel dispensers.

The practice had a legionella test certificate which was dated December 2014. Legionella is a germ found in the environment which can contaminate water systems in buildings.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was well equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic.

Staff told us that all equipment was tested annually and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that relevant equipment such as blood pressure monitors and weighing scales were regularly calibrated to ensure they were operating safely and effectively.

Staffing & Recruitment

The practice had a recruitment policy, however this did not include information about the specific checks the practice undertook in relation to recruitment. For example the need for criminal records checks via the Disclosure and Barring Service (DBS) and checks on professional registration. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment which included proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. We noted that the practice were awaiting a DBS check for one member of staff. There had been a delay in requesting this due to a communication error within the practice. We contacted the practice following the inspection and they confirmed the DBS check had been received. The practice manager checked on an annual basis that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number and mix of staff 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 there were enough staff on duty. There was also an arrangement in place for members of nursing, dispensary and administrative staff to cover each other's roles. Staff were paid overtime when this was needed. Staff we spoke with confirmed that this happened and these arrangements worked well. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety handbook which all staff had a copy of. Health and safety information was displayed for staff to see and refer to. During the inspection we noted that the health and safety risk assessment was not reflective of the service. We were sent an updated version following the inspection which was reflective of the service and covered a range of areas including manual handing, fire and control of substances hazardous to health (COSHH) .

The practice did not have a formal risk register, although we saw evidence that some of the risks being managed by the surgery were discussed and planned for. This included for example the temporary cessation of the extended hours appointments on Monday being discussed at the partners away day. The practice manager sent us a copy of the risk register that was set up following our inspection in order to manage and take action in relation to any risks identified by the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff we spoke with were aware of the panic alert system in the practice. Staff had received training in basic life support.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and

records we saw confirmed these were checked regularly. Adequate supplies of emergency equipment were available. We noted there was an oxygen mask which was unsealed and dirty and stored with the emergency equipment and was not safe to be used. We spoke with the practice manager about this who advised that it would be removed. Additional sealed oxygen masks were available.

Emergency medicines for the treatment of anaphylaxis were available in a secure area of the practice and all staff knew their location. Anaphylaxis is a sudden allergic reaction that can result in rapid collapse and death if not treated. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. The medicines in the anaphylaxis kit that we checked were in date and fit for use. Other medicines for emergency use were held in the dispensary and staff reported they would obtain them from the dispensary if this was necessary.

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. For example, contact details of the electricity supplier to contact in the event of failure of the electricity supply. We saw that this was reviewed on an annual basis and a copy was stored off site.

There was no fire risk assessment in place, although some checks were in place to maintain fire safety. We noted that the fire extinguishers had been tested. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. One day after the inspection, the practice manager confirmed that they were going to arrange for the local fire training officer to undertake the fire risk assessment and later confirmed that a date had been arranged for this to be completed. We were sent a copy of the completed fire risk assessment which concluded that some improvements were needed.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. 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. We saw minutes of weekly practice 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 evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The practice manager told us that GPs and nurses lead in specialist clinical areas such as diabetes, asthma and osteoporosis. The practice nurses ran a number of clinics which allowed the practice to focus on specific conditions. Practice staff and patients told us that they were reviewed regularly for their long term conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. The review of the practice meeting minutes confirmed this happened.

The practice also used a risk profiling tool which identified patients who may be at risk of being admitted to hospital, were overdue for screening, for example in needing a blood test, or due to their medicines. This risk profiling tool was accessed weekly to identify patients who may be at risk and alerts were then sent to the GPs for action as appropriate.

We saw no evidence of discrimination 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 patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. We were told that patients on high risk medications were monitored on a monthly basis and the results were reviewed by a practice nurse and appropriate actions taken, if this was necessary. The data management staff explained that information they collected was collated and used to support the practice to undertake clinical audits.

The practice showed us three clinical audits that had been undertaken. Two of these were completed audits where the practice was able to demonstrate the improved outcomes for patients. For example, urinalysis (urine testing) was now undertaken to check for urological damage, which had been identified in some patients. Another clinical audit related to improved outcomes for patients who were at the end of their life.

GPs in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and National Institute for Health and Care Excellence (NICE) guidance. We found that GPs who undertook minor surgical procedures were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used that in their learning.

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 QOF data showed that the practice had a higher prevalence of diabetes than the CCG and England average and scored higher than the CCG and England average for all the clinical indicators for diabetes. The practice met all the minimum standards for QOF in asthma, chronic obstructive pulmonary disease (lung disease), heart failure, osteoporosis, cancer and palliative care. This practice performed below the CCG and England average for learning disability.

Good

Are services effective?

(for example, treatment is effective)

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 the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert, the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

Effective staffing

All new staff underwent a period of induction at the practice. This was tailored to the specific role of each member of staff. We saw evidence that these had been completed for recent new starters. All new staff were given an employee safety handbook which included information on health and safety and fire safety. The staff we spoke with confirmed that this had happened.

The practice staff 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 basic life support, fire safety and safeguarding adults. The practice provided evidence that they were trying to source face to face safeguarding children update training. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We were told that the annual appraisal for this year had not yet been completed for all of the nursing staff, however these were all scheduled. The nursing staff we spoke with felt supported by the practice, were able to raise any issues they had and felt that they would be resolved. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example attending diabetes conferences. As the practice was a training practice, doctors who were in training to be qualified as GPs offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. This included administration of vaccines, cervical cytology and ear syringing. Those with extended roles, which included seeing patients with long-term conditions such as asthma, diabetes and osteoporosis were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, x-ray results and letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had an identified 'duty' doctor who was responsible for reviewing these documents and results and for undertaking the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries not being 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 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 saw that the process in place for responding to hospital communications was working well in this respect.

The practice held integrated care meetings on a monthly basis to discuss the needs of complex patients, those at risk of admission to hospital and those who are currently in hospital. These meetings were attended by the integrated care coordinator, the community matron, physiotherapists

Good

Are services effective?

(for example, treatment is effective)

and community nurses. Decisions about care planning were documented in a shared care record. Staff felt this work was invaluable at keeping patients out of hospital and cared for in their own homes or in the community and helped towards them having a smooth discharge from hospital.

The practice worked closely with local hospices, the community matron, community nursing team, the cancer care coordinator and a dedicated Macmillan nurse. This included attending 'Going for Gold' meetings which were held on a quarterly basis to discuss the patients with palliative care needs and ensure appropriate care and support was in place.

The practice had 118 patients registered from eight care homes. Each GP partner took responsibility for patients using these services. GPs undertook urgent visits when these were requested and also scheduled dedicated time every month for routine care home visits. Care home representatives we spoke with confirmed that medication reviews and revision of care plans were undertaken during the monthly visits. We received positive feedback that the practice was responsive to patients needs and provided sound clinical care.

Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals. Following the inspection the practice provided evidence that since April 2014 to December 2014, 100% of referrals which could be made through the Choose and Book system had been. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment.

The practice had systems in place to provide staff with the information they needed. An electronic patient record, called 'EMIS' was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We saw that the practice had a consent policy and consent forms. The clinicians we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary, for example when patients needed minor surgery. 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 demonstrated an understanding of legal requirements when treating children. The practice nurse confirmed consent was always obtained from parents prior to immunisations being given. All clinical staff we spoke with demonstrated a clear 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 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 clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

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 & 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. Information about mental health and domestic violence advice and support was prominently displayed in waiting areas with helpline numbers and service details. The practice website referred patients to a range of information supplied by NHS Choices. This included information on family health, long term conditions and minor illness.

Good

Are services effective?

(for example, treatment is effective)

We saw that new patients were invited into the surgery when they registered, to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. The new patient health check was undertaken by a nurse. 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.

We were told about the teenage health assessment appointments where patients reaching their 16th birthday were invited to attend a health assessment with a nurse. We noted in the patient information leaflet that a primary care mental health worker attended the practice one day a week. Patients could access this service by a referral from their GP.

We noted a culture amongst the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40-75 and these were undertaken by a nurse or health care assistant. Practice data showed that 95 patients in this age group took up the offer of the health check from October to December 2014. A GP showed us how patients who had risk factors for disease identified at the health check were followed-up by a GP and were scheduled for further investigations if appropriate.

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 10 of the 29 patients with a learning disability (35%) had attended for an annual health check. We were told that despite invitations being sent, several patients with a learning disability had not attended for this check. Improvements were needed to ensure that vulnerable patients were followed up appropriately. Following the inspection, the practice manager confirmed that all patients with a learning disability had now received an annual health check.

At the time of the inspection, the practice's performance for cervical cytology uptake was 78%, for health checks for people with dementia it was 67% and for health checks for people with mental health needs it was 70%. 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 in these areas. Practice staff advised that they were expecting to reach the targets that had been set in relation to these areas.

Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. Through discussion with staff and from records viewed, we saw that the practice performed well and had a high uptake for both childhood immunisation and vaccinations.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & 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. All of the patients we spoke with, and received comments from during the inspection made positive comments about the practice and the service they provided. Patients reported that all the staff were friendly and helpful and they were happy with the care that they received.

We saw that patient's confidentiality was respected when care was being delivered and during discussions that staff were having with patients. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

In the waiting room and hallways, the radio was on which helped minimise patients being overheard at the reception desk. Reception staff told us that facilities were available for patients to talk confidentially when they were at the reception desk. The practice manager confirmed the day after the inspection that notices were now displayed in the practice to inform patients that this was available. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff we spoke with were aware of their role in relation to confidentiality.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (96%) and by their GP (90%). 92% of patients reported that the reception staff were helpful. In relation to whether staff listened to them 99% reported this being good for nurses and 98% for GPs. 98% of respondents described their overall experience of the practice as good and 90% of patients stated they would recommend the practice. These results were above average when compared with other practices in the CCG area.

We also reviewed 29 comment cards that had been collected from patients in advance of our visit. All of the cards reported positive experiences of patients. Some of the cards referred to doctors by name, singling out individual examples of kindness, care and compassion.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey, published on 8 January 2015, showed 95% of practice respondents said the GP involved them in care decisions, 91% felt the GP was good at explaining tests and treatments and 92% said the GP was good at giving them time. In relation to nurses: 86% said they involved them in care decisions; 96% felt they were good at explaining tests and treatments and 98% said they were good at giving them enough time. The majority of these results were above average when compared with other practices in the CCG area.

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.

Patient/carer support to cope emotionally with care and treatment

Literature in the form of leaflets and posters were displayed in the waiting room area signposting a number of support groups and organisations that could be accessed for patients, relatives and carers. These included information about support for those suffering from long term conditions such as cancer and diabetes and advice for carers in relation to equipment and benefit payments.

Good

Are services caring?

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 also carers on the computer system so staff and clinicians were automatically alerted to patients who were also carers. This ensured that GPs and clinical staff were aware of the wider context of the patients' health needs. Notices in the waiting room and on the practice website signposted patients to a number of support groups and organisations for carers. West Norfolk Carers visited the practice every month and registered carers could see them on a drop-in basis in order to obtain support and advice.

Staff at the practice offered emotional and practical support for those who had recently suffered a bereavement. Staff told us families who had suffered bereavement were identified and the electronic records system was updated to inform all staff at the practice. This helped to ensure that when a bereaved patient attended the practice, staff were able to respond appropriately. They told us that recently bereaved families were called by their usual GP. This call was either followed by a consultation at the practice, or a home visit where this was more appropriate. In addition to the support provided by the practice staff, we were told that patients were referred to local external organisations that provided specialist services.

Information was available on the practice website which provided practical information in the event of a persons' death. There was also a variety of written information available to advise bereaved relatives and direct them to the locally and nationally available support and help organisations.

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 people'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. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs. Patients with diabetes who needed to start taking insulin had this initiated at the practice to save them travelling. Patients with complex diabetes were reviewed by the Norfolk Community Health and Care NHS Trust Diabetes Educator and practitioner in conjunction with the clinicians at the practice. This was to ensure continuity of care and to save patients having to travel.

There had been very 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 and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to some of the local care homes on a specific day each week by a named GP and to those patients who needed one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.) This included improved access to appointments for working patients and improved waiting times. 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.

The PPG informed us that they held monthly information sessions during which they invited external speakers to present on specialist subjects and long term conditions to the PPG, patients and general public. They told us that the GPs from the practice would occasionally present on these sessions too.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal, as well as multidisciplinary meetings to discuss patient and their families care and support needs. We received positive feedback from representatives of two care homes where patients were registered with the practice. This was in relation to the proactive support and care provided by the GPs to the patient, their family and their carers at the end of their life.

Tackle inequity and promote equality

The practice had an equality and diversity policy and recognised the needs of different groups in the planning of its services. The premises and services had been adapted to meet the needs of people with disabilities. There was a reserved disabled parking bay, an induction loop and a repeat prescription box at a suitable height so that it could be accessed by people using a wheelchair. The practice leaflet was printed in different languages which included Polish, Portuguese, Lithuanian and Russian.

The practice had access to INTRAN translation services. This service was predominantly a telephone based service, however translators could be requested to attend the practice if required. The service offered British Sign Language interpreters, lip speakers and interpreters in 150 languages. The practice identified on the patient's record if they needed an interpreter and this was booked in readiness for their consultation. We were told that longer appointments were given when interpreters were used to ensure there was adequate time for an effective consultation. We were told that one of the GPs spoke different languages and some patients chose to see them for their consultation.

We were told that the practice was responsive to the needs of patients who were travellers and when they visited the practice, rather than booking an appointment, they were offered an appointment to sit and wait to see a GP or nurse, as appropriate to their need.

Access to the service

The practice was situated in a single level building, near the centre of Swaffham and had a short stay free car park opposite the surgery. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the urgency of their health need.

The practice had offered extended hours appointments on a Monday evening but had needed to temporarily stop this service as they did not have enough GP capacity. We noted that this issue was going to be discussed at the partners away day planned for later in January. Staff we spoke with explained that when all the urgent appointments for the day had been taken, patients were asked to come to the practice at 6pm and wait to be seen by a GP. We were told by the practice manager that in the week before this inspection, the practice had seen 22 patients this way.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015 and found that 90% of patients described their experience of making an appointment as good and 95% said the last appointment they got was convenient. 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. The majority of the comments cards gave positive feedback on the appointments system and there was an appreciation that the practice staff were working hard to meet the needs of the patients. The feedback on two of the comments cards reported some dissatisfaction with the length of time to get a routine appointment.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There was information on making a complaint in the practice patient information leaflet and on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint but they believed that any complaint would be taken seriously.

We looked at two complaints received in the last twelve months. These had been acknowledged, investigated and a response had been sent to the complainant. 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 weekly practice meetings in order to identify areas for improvement and share learning. Complaints were also reviewed on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon and shared.

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 of providing holistic patient care. Although this vision was not documented formally, staff we spoke with told us that patients were the priority at the practice and we saw evidence of holistic care, particularly in relation to end of life care.

We were told the practice had held away days for the practice team every two years where future issues were discussed and planned for. We looked at the minutes from the away days. We noted that an away day for the partners was planned in January 2015. We were told that discussion would include the strategy for the practice and how they would plan the services they provide in response to the new housing development that was planned.

Governance Arrangements

The practice had dedicated GP and managerial leads responsible for governance. There were clearly identified lead roles for areas such as complaints, safeguarding and information governance. These responsibilities were shared between the GP partners. Clinical staff also had lead roles in relation to their clinical expertise. For example, there was a lead nurse and GP for asthma, diabetes and Chronic Obstructive Pulmonary Disease (COPD). (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.) The staff we spoke with were aware of their own roles and responsibilities and knew who had lead responsibility in the practice. It was clear that staff could go to any of the GPs for advice regarding any of these roles.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice and also in hard copy in a folder in the reception area. The staff we spoke with were able to locate policies and guidance when we asked for these during the inspection. There was scope to better record when policies were due to be reviewed. The practice manager sent information to CQC the day after the inspection to show that this feedback had been taken on board. A member of staff had been given specific responsibility to ensure that the policies were reviewed in a timely way and that this continued on an on-going basis.

The practice manager, GPs and nurses met weekly to discuss business and clinical issues. We saw the minutes of these meetings and they were available in the coffee room for all staff to view. They included complaints, significant events, updates to guidance, safety alerts and sharing of good practice. There were arrangements for learning from incidents, significant events and complaints. We saw that appropriate changes were implemented to help to prevent them reoccurring and to ensure the practice improved outcomes for patients

Feedback from infection control audits and other risks identified by staff at the practice were raised at the weekly practice meeting. There was no risk register at the practice as issues were raised on an informal basis. However following the inspection, the practice manager sent CQC a copy of a risk register that had been written for the practice. This identified the risks to the practice and actions to be taken in relation to those identified risks. This included the fire risk assessment. There was evidence that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice had identified named members of staff in lead roles. For example, there was a lead nurse for infection control, a GP lead for safeguarding and a GP for the dispensary. We spoke with a number of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice if they had any questions or concerns regarding these areas.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or discuss with the practice manager or their line manager. There were a number of staff meetings held at the practice. These included monthly clinical educational meetings, three monthly clinical governance meetings and weekly clinical and business meetings, which were shared with all staff via a noticeboard in the staff area. We were told by the practice manager that they had an away day every two years which was used to discuss future issues and for team building. We also noted that an away day was planned later in January to discuss how the practice was going to respond to a planned major housing development.

Are services well-led?

Good

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

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, suggestions and complaints. Patients were also able to feedback their suggestions via a 'suggestion box' in the waiting area. The practice had an active patient participation group (PPG) and had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from this group. (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.) This included improved waiting times and improved access for people who worked, by having early morning and late evening appointments. The PPG told us that a patient survey was undertaken in 2013 which identified that patients were satisfied with the care at the practice. We viewed the results of the survey which were available on the practice website. We saw that an action plan had been agreed which included improvements to the seating in the practice and raising awareness of the on line booking of appointments. We saw evidence that these actions had been completed during our inspection.

The practice had gathered feedback from staff through staff away days, staff meetings, appraisals and discussions informal discussions. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues. Staff were aware of how to raise suggestions and concerns with management and all of the staff we spoke with said that they would feel confident to do this and would be listened to.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice or in the policy folder in reception. Staff we spoke with were aware of whistleblowing and appropriate examples of when they would 'blow the whistle' were provided. However staff felt that this was not likely in this practice as opportunities were available to raise concerns and staff were listened to.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice nurses had specialist areas of interest and expertise and were supported by a GP with an interest in this clinical area. The clinical staff we spoke with felt supported by the practice and commented positively on the clinical support they could easily obtain from the GPs.

We were told that staff regularly attended local peer support meetings, which included practice manager meetings and diabetes meetings. The clinical staff also attended monthly educational meetings where they had an external speaker, or undertook prescribing reviews or internal audits. Staff we spoke with confirmed that these educational meetings occurred. All the staff we spoke with told us that the practice was very supportive of training and that they had clinical governance meetings every three months which included a section on training.

The practice was a GP training practice and was involved in the training of GP registrars. GP registrars are qualified doctors who are undertaking further training to become GPs. We did not speak to any GP registrars as part of this inspection. We received information regarding the National Training Scheme 2014 outliers, which identified workload as an issue for Campingland Surgery. This supported the feedback that we received from the GPs, practice manager and patients who felt that the GPs in particular were managing a significant workload between them.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients were not protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the dispensing of medicines.**