Swan Lane Surgery

Quality Report

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Essex
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Date of inspection visit: 10 February 2015
Date of publication: 23/04/2015

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 Swan Lane Surgery on 10 February 2015. Overall the practice is rated as good.

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

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.
- Systems were in place to record, monitor and review safety issues. 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 or nurse and 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.

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

Importantly the provider should;

- Provide role specific safeguarding training for staff, including those required to undertake chaperone duties

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. Most staff were aware of reporting procedures for safeguarding, significant events and complaints that affected patient safety. Staff were encouraged to report all incidents. Learning took place either informally or at regular team meetings. Risks to patients were assessed and well managed. The practice had robust infection control procedures. Medicines were stored correctly and monitored for expiry dates. There were enough staff to keep patients safe. Some staff had not received safeguarding and chaperone training.

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. They were aware of their practice population and provided services that met their needs. 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 were qualified and skilled to carry out their roles. They had received appropriate training any further training needs had been identified and planned to meet the needs of patients. 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 the appointment system met their needs. It was easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same

Summary of findings

day. Appointments in advance could be booked for any time period. The practice was aware of their patient population and tailored their services to their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Health advice and guidance was available for patients to access.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and 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. They were aware of their elderly patient population and each patient had a named GP. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people. It was responsive to the needs of older people, and offered emergency appointments, home visits and telephone consultations for those who required them. The practice offered senior health checks for the elderly and a vaccination service was available for the prevention of flu, pneumococcal illnesses and shingles. The practice participated in the Direct Enhanced Service Admission Avoidance service to monitor elderly patients at risk of admission to hospital. This involved multidisciplinary meetings where individual patients care and treatment was discussed to identify a treatment plan to maintain their health. The practice was also in the process of setting up a 'virtual ward' with other healthcare professionals to enhance the care of their patients to avoid hospital admissions.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients with chronic illnesses such as diabetes, asthma and chronic obstructive pulmonary disorder were regularly reviewed every six months or annually if their condition was stable. Advice and guidance about their condition was available from qualified clinical staff. Patients at risk were included on a register so their condition could be monitored and a care plan developed to reduce unnecessary hospital admissions. Patients were supplied with antibiotic rescue packs when required. Medicines were reviewed regularly to ensure they were effective and necessary. Patients received flu vaccinations if their conditions made them susceptible to the illness. Longer appointments and home visits were available when needed. All these patients had a named GP. The practice used the Single Point of Referral (SPOR) so that patients could be assessed the same or next day by a district nurse and social worker if they became ill.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided baby and post-natal checks, vaccinations for pregnant women and childhood vaccinations. The GP co-ordinated care for mothers and babies with the local hospital

maternity services. The practice had a 'looked after children' register for vulnerable children and these were monitored regularly involving other healthcare professionals. Staff had been trained in safeguarding procedures for children. Children and young people were treated in an age-appropriate way and were recognised as individuals. Staff were aware of the Gillick competence test if children wished to see a GP or nurse without a parent or guardian being present. Regular liaison with the local health visitor and school nurse took place who attended multidisciplinary meetings to discuss families in need of additional support. Immunisation rates were high for all standard childhood immunisations.

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 practice was aware of the needs of the working age population, those recently retired and students. These 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 offered a wide range of appointments from 8.40am to 6.20pm Monday to Friday, with extended hours until 8pm on Wednesdays. Health checks for those aged between 40 and 74 were available through the appointment system or at a dedicated clinic.University students could be registered as temporary patients when they returned home during their holiday.

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 with a learning disability and this was monitored to ensure they received an annual health check and follow-up with a GP if required. Longer appointments for people with a learning disability were available if required. The practice supported homeless people who were vulnerable, with health checks and support with external agencies. Counselling and support was available for patients with alcohol addiction by practice staff. Members of the travelling community received consultations, care and advice related to their medical needs.

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). They were aware of the numbers of patients in this group and their healthcare needs. All had received regular health checks and reviews of their medicines. Longer appointments were given to patients to help

understand their condition and to provide the appropriate advice. Referrals to specialists were made in the more complex cases. Patients were signposted to external organisations that could provide additional support. A mental health counsellor from an organisation known as 'Therapy for You' attended the practice to provide support for patients suffering with depression. Clinical staff had received training in mental health capacity assessments and deprivation of liberty safeguards in line with the Mental Capacity Act 2005. Patients with memory impairment were referred to a memory clinic for early diagnosis and treatment if indicated. Patients with dementia had an annual health review undertaken by their GP or by the community dementia nurse. The practice liaised with the local dementia crisis team so that patients could be treated effectively and remain in their home as long as possible.

Summary of findings

What people who use the service say

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 46 cards that had been left for us and reviewed the comments made.

All of the comment cards we viewed contained complimentary comments about the GP, nurse, reception staff and the services provided. Patients commented that the GP and nurse were excellent, spent time listening to their concerns and explained their care and treatment in a way they understood. They said that appointments were readily available and reception staff were kind, caring, polite and friendly. Overall patients were very satisfied with the services they received.

We spoke with four patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. We were told that appointments were generally always available and they were rarely kept waiting. They told us that explanations were clear and care and treatment was delivered to a satisfactory standard.

The practice carried out a patient survey in April 2014 and 60 patients took part. The results of that survey reflected that 52 0ut of 60 patients were very satisfied with the services provided. The survey highlighted two areas of feedback of a minor nature and the practice responded to these by making improvements.

The patient had an active patient participation group that worked with the practice to discuss areas for improvement. We spoke with a member of that group on the day of the inspection. They told us that there was a positive relationship between the practice and the group and their views were listened to and acted on where relevant. We were told that there were high levels of satisfaction amongst patients who used the practice.

Areas for improvement

Action the service SHOULD take to improve

Provide role specific safeguarding training for staff, including those required to undertake chaperone duties

Swan Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector accompanied by a GP specialist advisor.

Background to Swan Lane Surgery

Swan Lane Surgery is situated in Wickford, Essex. The practice is one of 44 GP practices in the Basildon and Thurrock Clinical Commissioning Group (CCG) area. The practice has a general medical services (GMS) contract with the NHS. There are approximately 2900 patients registered at the practice.

There is one full time female GP working at the practice and one part-time female nurse. They are supported by two part-time practice managers and reception staff. The practice uses locum GPs and nurses when the need arises but occasions are rare. It is not a dispensing or a training practice.

The surgery is open each weekday from 8am to 6.30pm and has a late night surgery on a Wednesday until 8pm. They are closed at weekends. The practice has opted out of providing 'out of hours' services to their own patients so patients contact the emergency 111 service to obtain medical advice outside of normal surgery hours.

Facilities at the practice include parking at the front of the premises. The practice is accessible by public transport.

There has been no information relayed to us that identified any concerns or performance issues for us to consider an inspection. This is therefore a scheduled inspection in line with our national programme of inspecting GP practices.

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

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We then carried out an announced visit on 10 February 2015. During our visit we spoke with a range of staff including the GP, nurse, practice manager and reception staff. We spoke with patients who used the service and a member of the patient participation group. We observed how people were being cared for and talked with carers and/or family members and reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice and we viewed them afterwards.

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

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

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

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included the analysis of significant events and complaints as well as acting on general comments received from patients and staff.

The GP at the practice reviewed all national patient safety alerts and Medicines and Healthcare Products Regulatory Agency (MHRA) notifications. Where these affected particular patients they were notified and action taken accordingly, such as prescribing an alternative medicine. Patient records were then updated.

Staff we spoke with were aware of their responsibilities to raise concerns, knew how to report incidents and near misses and were encouraged to do so. Team meetings took place regularly and safety was a fixed agenda item but the minutes of the meetings were not always fully recorded.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, complaints, incidents and accidents. Staff were encouraged to record incidents and bring them to the attention of the GP or practice manager.

The practice had only received one complaint in the last 12 months and this had been recorded and dealt with effectively. A significant event had also occurred in March 2014 and the analysis and outcome had identified an improvement area that had been actioned and acted upon. Staff had been made aware of the incident and a change in their system put in place to prevent a recurrence.

Staff meetings took place regularly. We viewed the minutes of the last three meetings and found that learning from incidents/complaints was a fixed agenda item but the minutes lacked detail. However staff we spoke with confirmed that they were aware of the incidents and had learned from them. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were managed by the GP at the practice and individual patients care and treatment reviewed where necessary. The GP we spoke with was able to give examples of recent alerts that were relevant to the care of their patients and how they dealt with them to keep patients safe. This included changing medicines where necessary or arranging for a consultation with them to discuss the issues. The GP cascaded all relevant clinical information to the nurse at the practice.

Reliable safety systems and processes including safeguarding

The practice had appointed the GP as lead for safeguarding vulnerable adults and children. They were able to demonstrate that they had received the necessary training to enable them to fulfil this role. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff at the practice were aware of the identity of the lead member of staff. The nurse at the practice had also received safeguarding training. Both the GP and the nurse knew how to recognise the different types of abuse and how to report them. They were aware of external agencies who could provide support and how to contact them if necessary.

Staff were encouraged to report any incident to the GP or nurse if they had a safeguarding concern.

We looked at training records and found that clinical staff had received safeguarding training. However not all other staff had received relevant role specific training on safeguarding but were aware of the different signs of abuse in older people, vulnerable adults and children. We discussed this with the practice on the day of our visit and they have agreed to provide some training relevant to their role, particularly as non-clinical staff occasionally acted as chaperones when patients were having consultations.

The practice had systems to manage and review risks to vulnerable children, young people and adults.

There was a system to highlight vulnerable patients on the practice's electronic records. Codes were used to identify those at risk and this alerted staff that they were patients who were at risk, such as children subject to child protection plans.

There was a chaperone policy in place and signs were displayed in the reception area to inform patients that this service was available. (A chaperone is a person who acts as a safeguard and witness for a patient and health care

professional during a medical examination or procedure). The nurse at the practice had received chaperone training and was the preferred member of staff when one was required. When unavailable, non-clinical staff were called upon to undertake this role. We spoke with two of these members of staff on the day of our visit and found that they had not received any formal training. It was evident from speaking with them that they were unsure of the procedures to follow and in particular where to stand during an examination. We have discussed this with the practice which agreed to provide training for them in the future.

The practice had a whistle blowing policy and staff we spoke with were aware of it, had read it and knew who to contact if an issue arose, including the details of external organisations they could contact if they so wished. They told us they were encouraged to raise and issue and felt confident that it would be dealt with in a professional manner.

The practice had a system for following up patients who failed to attend appointments for childhood immunisations and for cervical smear testing.

Medicines management

Medicines were reviewed by a GP on a monthly basis to check they were effective and remained necessary. Where required, patients had to undertake a blood test to ensure they were safe to issue. Repeat prescriptions were signed by a GP only after being checked whether a review was due. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We found that prescriptions that had not been collected by a patient were shredded for security purposes. However we spoke with the GP about this and established that there was no clinical oversight when this occurred. We discussed this with the practice and asked them to review those prescriptions not collected, before shredding, so that each patient concerned is considered to ensure that they are not at risk of their health deteriorating by not taking the medicine that had been prescribed for them. This is particularly relevant to patients with long-term health conditions, those with complex needs, the elderly and those suffering from poor mental health. The practice agreed to do so.

We checked medicines stored in the treatment rooms and medicine fridges and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurse had received appropriate training to administer vaccines and legal requirements and national guidance was being followed.

The practice had established a service for patients to pick up their dispensed prescriptions at a local chemist and to order repeat medicines from the practice via the chemist. This information was available to patients at reception and in the practice leaflet

The practice monitored their prescribing data from information supplied to them by the local Clinical Commissioning Group. They were aware of their performance across all of the indicators provided and had an effective system in place to ensure patients received the right medicines at the right time and that value for money was achieved. They were aware of the areas where improvements were required and were addressing them to improve their overall effectiveness.

Cleanliness and infection control

The GP and nurse at the practice had been appointed as the leads for infection control and they had been appropriately trained. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection.

A contract cleaner attended the practice each day to carry out general cleaning duties. A document was in place that explained the areas and equipment to be cleaned, the frequency and the cleaning materials to be used. These followed the guidance in the Control Of Substances Hazardous to Health Regulations (COSHH) 2002. These included the consultation rooms and the waiting room area. A checklist was in place for them to use. The cleaning was being monitored on a daily basis. We found the premises to be visibly clean and tidy.

Staff had ready access to personal protective equipment (PPE) and used it when required to do so. This equipment included disposable gloves, aprons and coverings. There

was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. There were adequate supplies of hand washing soaps and paper towels throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hand washing techniques were displayed in the toilet facilities.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

A clinical waste collection contract was in place with a company experienced in this process. Clinical waste was correctly packaged and safely stored whilst awaiting collection.

Infection control audits had been carried out in June 2013 and June 2014. This reflected that robust procedures were in place at the practice. Only a few minor issues had been identified for improvement and these had been actioned in a timely manner.

Equipment

Staff we spoke with told us they had sufficient amount of equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that equipment in use had been serviced and maintained and documentation was in place to support this finding. This also included the periodic calibration of equipment such as blood/sugar and blood pressure monitoring devices.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

The practice had a recruitment policy that described the procedure they followed when considering employing new members of staff. This included the need to undertake appropriate recruitment checks prior to employment, such as proof of identification, references, qualifications and registration with the appropriate professional body. The policy did not make it clear when and for which roles a criminal records check should take place through the Disclosure and Barring Service (DBS). At the time of our inspection the correct checks had been made on staff working at the practice.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place to ensure that enough staff were on duty. The practice staff were small in number and able to deputise for each other if one was absent through illness or annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

The practice occasionally used a locum GP or nurse. An effective system was in place to ensure that they were suitably qualified and experienced to carry out the role. There was also a formal induction process in place for them to follow to ensure they were familiar with the services provided and the way the practice was managed.

Monitoring safety and responding to risk

The practice had a health and safety policy that was designed to protect staff and patients at the practice. Staff had received health and safety training. A health and safety risk assessment had been undertaken which had identified the type of risk and the measures to take to reduce such risk. The risks identified included environmental issues such as frayed stair carpets and slippery steps in addition to risks associated with infection control procedures.

We found that these risks were reviewed every six months when the lead for health and safety would inspect the premises for any new issues. We found that this review was not being recorded but the practice agreed to do so in the future. It was evident however, that steps had been taken to make necessary repairs when required.

Other systems were in place to monitor risk including infection control, medicines management, dealing with emergencies and the servicing, maintenance and calibration of medical equipment.

The practice had access to the local mental health crisis team for patients experiencing deterioration in their mental health that may have put themselves and others at risk.

Arrangements to deal with emergencies and major incidents

Are services safe?

Staff we spoke with were aware of the location of the emergency medicines and were able to access them in an emergency.

The GP had an emergency medicine bag that they took with them when visiting patients in their home. We found that this was stocked with appropriate medicines and these were checked regularly to ensure there were adequate supplies and they were all within their expiry dates.

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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.

Practice staff were aware of fire evacuation procedures and fire extinguishers were in date and readily available. However a practice fire drill had not taken place at the practice, but they confirmed one would be undertaken in the near future.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with the GP and nurse on the day of our inspection and were satisfied that care and treatment was being delivered in line with best practice and legislation. They were aware of the guidance provided by the National Institute for Health and Care Excellence (NICE) and how to access

the guidelines.

There was an effective system in place to monitor national patient safety alerts and medicines and health care products. These were sent to the practice and reviewed by the GP who made appropriate clinical decisions. The information was then disseminated to the nurse and other staff if relevant to their role. This ensured patients received effective consultations and treatment.

The GP and the nurse were allocated lead roles in relation to conditions such as diabetes, heart disease and asthma. Patients with these conditions were seen and monitored through the appointment system rather than holding a separate clinic. Data held in relation to the performance of the practice reflected that they were effective in providing regular screening to ensure patients received appropriate care and treatment to manage their condition.

Patients with long term conditions and those approaching the end of their lives through illness had their needs assessed and were provided with effective care and treatment. Patients and their carers/families were signposted to support from external organisations, such as Macmillan nurses and health visitors.

Where an assessment revealed a more complex diagnosis, patients were referred to specialists and other services in a timely manner and where urgent, often on the same day. The GP was responsible for the referrals and supported patients to choose and book a specialist of their choice.

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

Management, monitoring and improving outcomes for people

The practice monitored their performance using the Quality and Outcomes Framework (QOF). The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. QOF data showed the practice performed well in comparison to the national average.

The QOF was the subject of regular review to ensure the practice was on target to meet their objectives. These included their performance in such areas as flu vaccinations, cervical smear testing, child immunisations, diabetes monitoring and health reviews for persons suffering from poor mental health or with learning disabilities. The practice was aware of their performance across each area that was being measured and they were meeting the majority of the standards for the QOF.

In relation to the national child immunisation programme the data available to us reflected that they had achieved 100% for the children that were registered at the practice. This was the subject of a quarterly performance review to assess the progress being made against their targets. As far as diabetes monitoring was concerned they were aware that their performance was lower than the area average but were taking steps to improve their performance. This included reminders to patients to have their blood tested regularly at the local hospital.

The practice had carried out a number of audits. These included cancer diagnosis and referral rates and fragility fracture analysis. The outcomes of these audits identified areas for improvement and action had been taken to improve future outcomes for patients. They also monitored their prescribing data to ensure positive outcomes and value for money was achieved for their patients.

We saw the results of audits and performance monitoring had been shared with the staff at the practice at their team meetings. Staff spoke of a culture of quality improvement and continuous learning within the practice.

There was a protocol for repeat prescribing which was in line with national guidance. Patients receiving repeat prescriptions had been reviewed by the GP. Repeat prescriptions could not be ordered by phone to ensure patient's safety. Routine health checks were completed for

Are services effective?

(for example, treatment is effective)

long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term conditions such as heart failure, dementia, type 2 diabetes or those patients at risk of falls were also placed on a register and their conditions monitored. Regular multidisciplinary meetings took place and their care and treatment was discussed on an individual basis to ensure they received the most appropriate treatment to enable them to live at home and to reduce the risk of avoidable hospital admissions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had stipulated the training areas and frequency of them so that staff skills met the needs of patients. This training was monitored regularly and refresher courses organised when appropriate. There was a mixture of face to face and eLearning training. Examples of their training included basic life support, fire training, infection prevention control and safeguarding.

Although we were assured that regular updates of training were taking place, some staff had not received safeguarding or chaperone training. We found that staff were aware of the role of the chaperone but did not fully understand where to stand in the consultation room when they were asked to perform the role.

We looked at a three staff records and found that appraisals were taking place annually, except for the part-time practice managers, which were overdue by several months, but being undertaken in the near future. The appraisal process included an opportunity for staff to reflect on their performance over the last year and to assess their training and development needs. The appraisal then took place with their manager. We found an example of where a member of staff had requested training on the computerised patient record system and had received it.

Staff spoken with told us that the appraisal process was fair and meaningful and if they requested training and it met the needs of the patients, it was then organised for them. We did note however that the appraisals did not contain a formal assessment of the staff member by the line manager.

Staff told us that the practice provided a supportive environment and the GP was available for any advice or guidance. Practice staff had regular training and continuing professional education through monthly protected “time to learn” sessions.

The practice nurse was able to demonstrate that they were trained to fulfil their duties and this was monitored. Examples of their training and qualifications included chronic pulmonary obstructive disorder, diabetes, gynaecology, asthma, hypertension and stroke management. The nurse was up to date with their yearly continuing professional development requirements.

The GP had received an annual appraisal and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice used a computerised patient record system known as ‘SystmOne.’ We found that staff were not trained to use this system to its full potential and this would benefit the practice for monitoring performance and communication within the practice.

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. These received clinical assessment from the GP and then patient records were updated.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, such as those with end of life care needs, long-term conditions or at risk of their health deteriorating rapidly. Care and treatment plans were put in place to manage their condition and to reduce

Are services effective?

(for example, treatment is effective)

the risk of unnecessary hospital admissions. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Patients with dementia had received an annual mental health review undertaken by the GP or by the Community dementia Nurse. Patients with memory impairment were referred to a memory clinic for early diagnosis and treatment if indicated. Liaison took place with the dementia crisis team who helped to keep patients at home safely as long as possible.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record known as 'SystmOne' was used by all staff to coordinate, document and manage patient care. Although staff had received some training on the system we found that it was not being used to its full potential.

We found that information was being shared appropriately between other health care providers and the practice in relation to their patients. Where hospital discharge letters had been received these were brought to the attention of the GP, action taken if necessary and the patients record updated in a timely manner.

When patients received 'out of hours' emergency treatment, information on the consultation and diagnosis was passed to the practice the following morning so that information about the patient was always current.

A 'choose and book' system was in use that enabled patients, referred for specialist treatment, to select their preferred hospital. Patients were supported to understand this system when required.

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. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. A consent policy was in place to support staff and it had been reviewed regularly.

Staff were aware of the different types of consent that could be taken including verbal and written. They were aware of the Gillick competence test and children wishing to attend without a parent or guardian were assessed by a clinical member of staff before care and treatment was given. This is a test 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

Patients wishing to register at the practice were offered a health check with the nurse to assess their health. The GP was informed of all health concerns detected and these were followed up in a timely way.

Chlamydia screening to patients aged 18 to 25 years and smoking cessation advice was available to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice identified patients who needed additional support, and it was pro-active in offering it. The practice was aware of the numbers of patients with a learning disability and they were offered an annual physical health check. Data available to us showed that the majority of these had already received their annual health check.

The practice had achieved their target of identifying smokers and offering them support, advice and offering them a referral to a specialist if required.

Patients eligible for the flu immunisation had been identified and contacted and the target achieved. Posters were displayed advising them of the date when flu vaccinations were available.

The practice's performance for cervical smear uptake was on course to achieve their target. There was a policy to provide reminders to patients who did not respond to letters or failed to attend for their appointments. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

The reception and waiting room area contained a range of information in leaflet and poster form to encourage people to live healthier lives. There were leaflets available on smoking cessation, dietary advice and chlamydia screening.

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 GP Patient Survey (2014-2015), a practice survey of 60 patients in 2014, the views of the practice's patient participation group (PPG) and feedback given to us from patients who had completed 46 comment cards. We also spoke with four patients on the day of our inspection.

The evidence available to us reflected that there was a high level of satisfaction amongst patients who felt that they were treated with compassion, dignity and respect. Data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good.

All of the comment cards we viewed 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 staff treated them with dignity and respect. Patients commented that the GP and nurse listened to them and were understanding and thoughtful.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception area had a glass partition so when the receptionist was on the phone, this was closed so that patients waiting for a consultation could not overhear any conversations.

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 practice manager.

Patients who suffered from poor mental health or living in vulnerable circumstances were welcomed at the practice and were treated with kindness and compassion. They were assessed and referred to support services wherever possible, including counselling. Clinical staff had received training on the Mental Capacity Act 2005 and offered extra time with patients to explain treatment and listen to what they had to say.

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 rated the practice highly in these areas.

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 without being rushed and that explanations about their care and treatment were clearly explained. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients who were elderly and vulnerable, those with long-term conditions or with complex issues were identified and recorded on a register. Their ongoing care and treatment was discussed with them and they were involved them in the care and treatment decisions and plans.

Patient/carer support to cope emotionally with care and treatment

The GP was informed if a bereavement had occurred and a protocol was in place to support relatives and their families. A bereavement pack was available to hand to family members that contained details of organisations and support services available. If required, patients could book appointments with the GP for further support.

There was a system in place to notify reception staff of a bereavement so they could offer appropriate support when patients attended the practice.

The patients we spoke with on the day of our inspection and the comment cards we received were complimentary about the staff at the practice and how they responded compassionately when they needed help and support.

Are services caring?

Staff were encouraged to identify friends and relatives who were undertaking roles as carers. This included asking new patients to the practice to indicate if they were a carer. One member of staff had received training as a carer's champion and there role was to provide additional support to patients that needed it. This included advice on mobility aids and how they could obtain government benefits.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The GP attended a monthly meeting organised by the locality Clinical Commissioning Group (CCG). This provided them with the opportunity to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice was aware of their patient population and the services provided were tailored to meet their needs. These included clinics and advice in relation to long-term conditions such as chronic pulmonary obstructive disorder, diabetes and asthma. Patients at risk of deteriorating health were identified and placed on a register so an individual care plan could be put in place and their health monitored to reduce avoidable hospital admissions.

Family planning was available for patients who could book an appointment with the nurse to receive appropriate advice. The practice also held well baby clinics where mothers could receive a post-natal check-up for themselves and an eight week check for their newly born child. Baby immunisation clinics were also held at the practice.

Systems were in place for older people to access the care they needed. Patients over 75 had a named GP and received continuity of care. As there was only one GP at the practice patients were able to see the GP of their choice.

The appointment system was effective for the various population groups that attended the practice. Appointments were available in the evening on a Wednesday up until 8pm. Longer appointments were available for patients with learning disabilities, those suffering from poor mental health and those with long-term conditions or complex needs. Home visits were available for those with limited mobility or otherwise unable to get to the practice.

Mothers and babies were able to readily access the GP or the nurse to receive ante and post-natal advice and treatment. Child immunisation vaccinations and cervical smear testing were also available in line with national programmes in place.

Vulnerable patients such as those with a drug and alcohol addiction or suffering with poor mental health were signposted to external organisations that could provide support to them. This included support from an organisation known as 'Therapy for You' which offered a wide range of treatments. They also had a mental health counsellor that attended the practice to speak with patients.

Patients with dementia received regular health reviews and had access to the community dementia nurse and the local crisis team where care and treatment could be assessed so that patients could remain living in their homes as long as possible.

Patients we spoke with and comment cards we viewed reflected that the GP and nurse always had time to listen to their concerns and they were not rushed.

Services were provided so that the elderly were able to receive their annual flu vaccinations and there was a system in place to remind them when these were due.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and from patient surveys.

Tackling inequity and promoting equality

The practice was available for patients to register with regardless of their personal circumstances or vulnerability. This included the homeless, travelling community, persons living with mental health, those with learning disabilities and any other vulnerable group. Registers were held at the practice so that appropriate support could be provided and monitored.

The premises and services available met the needs of people with disabilities. The consultation rooms were all situated on the ground floor of the building and accessible to all patients regardless of mobility issues. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to

Are services responsive to people's needs?

(for example, to feedback?)

the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Private parking was available for patients to use at the front of the premises.

Access to the service

The practice was open from 8.00am to 6.30pm from Monday to Friday, with a late night on Wednesday until 8pm.

Urgent appointments were available on the day. Patients could book appointments in advance for any time period and generally were able to select times and days that suited them. Home visits were available for older people or those with long-term conditions and unable to attend the practice. Telephone consultations also took place. Longer appointments were available for patients who needed them such as vulnerable patients and those suffering from poor mental health. The practice's extended opening hours on a Wednesday was useful to patients with work commitments.

The information we received from patients on the day of our inspection and from CQC comment cards that had been completed prior to our visited, indicated that patients were very satisfied with the appointment system. This was also evident from the results of the National Patient Survey from 2014 to 2015 which rated the practice as among the best in the local area and nationally.

Information was displayed in the reception area and on the practice leaflet that explained how to obtain emergency medical advice. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Listening and learning from concerns and complaints

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

The complaints procedure was visible on a notice board in the practice for patients to read. It explained the procedure to follow, the timescales involved and the details of other organisations that a patient could contact. The GP was also proactive in responding to complaints.

Staff we spoke with were aware of the procedures in place and they told us they tried to resolve the matter if they could, before referring it to the practice manager for investigation. Reception staff had ready access to complaint forms and supported patients if they needed it.

We viewed the record of one complaint that they had received in the last 12 months. It was clear from the record that the complaint was about secondary care and not the practice. However the practice had invited the patient into the surgery to discuss the issues and offer appropriate advice and support.

None of the patients we spoke with had ever needed to make a complaint about the practice and the comment cards we viewed contained no dissatisfaction with any of the staff or the services they provided.

Although there had been no other complaints in the last 12 months, team meetings were regularly held and included a fixed agenda item to cover learning identified from the complaints they received.

Are services well-led?

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

Our findings

Vision and strategy

Prior to the inspection, the practice provided us with an up to date statement of purpose. This clearly outlined the aims and objectives of the practice and their vision to deliver high quality care and promote good outcomes for patients.

It was clear from speaking with staff that they understood the vision and values of the practice and were working towards achieving them as a team. The results of the patient survey and the comment cards we viewed confirmed that the strategy was effective, being monitored and reviewed in order to achieve the stated aims and objectives.

Staff spoken with on the day of the inspection told us they were included in the vision and were working towards it as part of a team. Their job description and role were linked to achieving the objectives.

Governance arrangements

The practice had a range of policies and procedures and these were updated regularly to ensure they were fit for purpose. They were readily available for staff to read and they had signed them to indicate that they had done so and understood them.

There was a clear leadership structure with named members of staff in lead roles. These included safeguarding, complaint handling, infection prevention control and recruitment. Staff spoken with were clear about their own roles responsibilities. They felt valued and supported and were confident that they could raise any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. These included infection control, prescribing data, cancer referral rates and outcomes and a fragility, fracture and osteoporosis audit.

The practice had arrangements for identifying, recording and managing risks through a health and safety risk assessment. This was being reviewed every six months and monitored by the practice managers.

The practice held regular staff meetings where performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a clear leadership structure at the practice involving the GP and two part-time practice managers. All staff were involved in the practice and how it was run and managed. Regular team meetings took place every two months attended by the GP.

Staff we spoke with told us that there was visible leadership and that the managers were open and transparent and that it was a team working environment where every member of staff were able to contribute new ideas or suggestions. Staff had been allocated key areas of responsibility and felt involved in the management of the practice to achieve providing excellent care to their patients.

Staff told us that there was an open culture within the practice and they had the opportunity and were encouraged to raise issues at team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a survey of 60 patients carried out in the month of February to April 2014. The analysis revealed that 52 of those patients were completely satisfied with the practice and the way it worked and did not want any change. Two areas for improvement had been identified relating to the car park and television in the reception, and both had been actioned in a timely manner.

The practice had an active patient participation group (PPG) that met every three months and was attended by the GP and the practice manager. Minutes of meetings were viewed and they reflected that the meetings were being used effectively and to discuss where improvements might be made. We spoke with a member of the PPG on the day of our inspection who told us that the practice was supportive and willing to learn and act on suggestions where they added value for the patients. We were told that

Are services well-led?

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

there was a high level of satisfaction amongst patients. Minutes of meetings were displayed in the reception area and posters were present inviting other patients to consider joining the group.

We looked at the results of a national patient survey carried out by the NHS in 2013. This rated the practice highly in areas such as opening hours, ability to get through on the phone and experience of making an appointment. Of the patients surveyed, 96.3% graded the practice as good or very good overall.

The practice had gathered feedback from staff through staff meetings, appraisals or informally. Staff we spoke with told us they were encouraged to identify areas for improvement and where appropriate these were acted on. This included training needs that would benefit the needs of patients.

The practice was in the process of formalising the new NHS England Friends and Family test. This will be a requirement for practices in the near future where they will be expected to gather feedback from patients and their families on their views of the practice. Of the 168 people in December 2014 and January 2015, who were asked the question, "How likely are you to recommend our GP practice to friends and family if they needed similar care or treatment," 79% replied that they were very likely to and 20% replied they were likely to.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff were aware of the procedures to follow and felt confident they could raise any issue without fear of recrimination. They also knew which organisations they could contact outside of the practice if they needed to.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place which included training and development needs. Staff told us that the practice was very supportive of training.

The part-time practice managers attended a monthly area practice managers meeting where good practice and learning was discussed. Staff attending told us they found this useful and were able to share experiences and gather information that they were able to bring back to the practice to make improvements to the services they provided.

The practice had completed reviews of significant events, complaints and other incidents and shared the learning from these with staff at meetings to ensure the practice improved outcomes for patients.