Longshore Surgeries

Quality Report

Longshore Surgeries
Field Lane
Kessingland
Suffolk NR33 7QA
Tel: 01502 740203
Website: www.longshoresurgeries.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Longshore Surgeries on 08 October 2014. We visited the main surgery and one of the two branch sites. The inspection team was led by a CQC inspector and included two GP specialist advisors, a practice manage specialist advisor, a CQC pharmacist inspector and an Expert by Experience.

We found that Longshore Surgeries provided a good service to patients in all of the five key areas we looked at. The practice provided a good service to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- Longshore Surgeries were a caring practice with high quality committed GPs who provided a high level of personal care to their patients through the use of the "personal list" system. The staff were very committed to acting in the best interests of the patients.
- Patients were satisfied with the service and felt they were treated with dignity, care and respect and involved in in decisions about their care and treatment.
- There were systems in place to provide a safe, effective, caring, responsive and well led service.
- The needs of the practice population were understood and services were offered to meet these needs. The practice was proactive in helping people in vulnerable circumstances and had ensured they had access to healthcare and had arrangements in place to make sure their health was monitored regularly.
- The practice had chosen to become a training practice for registrar GPs and had developed a philosophy to ensure staff were well trained. This approach had enabled the practice to recruit staff and a partner GP. This had benefitted patients because the practice was better able to respond to the increased patient population demand.

We saw an area of outstanding practice where the practice has persevered over a few years to establish a regular GP visiting clinic at a traveller site. This proactive

Summary of findings

approach by the surgery had ensured that patient were registered with a GP practice and had access to primary care. In addition we found that this had prevented unnecessary visits to hospital Accident & Emergency departments.

However, there were also areas of practice where the provider should make improvements:

- The practice should ensure that when significant events are reviewed, any related learning points become a formalised part of the process and are recorded.
- The practice should ensure they keep under review known patient risks relating to the treatment of underactive thyroid, patients prescribed Warfarin and those patients receiving Lithium treatment.
- The practice should review their security arrangements for the accounting and recording of prescription pads and access to the branch dispensary.
- The practice should implement a system to check the quality of cleaning undertaken.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. NICE (National Institute for Health and Care Excellence) guidance is referenced and routinely used. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff received training appropriate to their roles. The practice can identify all appraisals and the personal development plans for their staff. Multidisciplinary working with other health and social care services was evident.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice high or almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

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 Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice listened and responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). 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. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example 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 and home visits.

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. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations.

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. We were provided with good examples of joint working with midwives, health visitors and school nurses.

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 offer continuity of care. The practice was proactive in offering online services 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

Outstanding ☆

The practice is rated as outstanding for the population group of people living in vulnerable circumstances.

An example of outstanding practice was how the practice had forged a positive relationship with a local traveller community and had over a period of time established a regular visit and onsite clinic to people who were reluctant to visit the surgery. We observed the positive and friendly interaction of one GP with this patient group when we accompanied them on a visit to the traveller site. We saw evidence that this planned and responsive approach to provide care had helped to reduce patients unnecessarily visiting a hospital Accident and Emergency department.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and most of these patients had received a follow-up reminder to attend their appointments. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had sign-posted vulnerable patients to social services and to various third sector support organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

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. 92% of people experiencing poor mental health had received an annual physical health check. 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.

Summary of findings

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency, or out of hours services, where there may have been mental health needs.	

Summary of findings

What people who use the service say

We spoke with 16 patients during our inspection. They varied in age and mobility. We spoke with two parents and with three others who had a long term condition. They all informed us that staff were polite and helpful. Patients told us they were involved with making decisions about their care and treatment. They all reported they were happy with the standards of care they received. Several patients informed us that they would recommend the practice and that they put a high value on the personal care and attention given by the GPs and nurses.

We collected 28 Care Quality Commission comment cards that we had left for patients. All of these comments were positive. Some patient described their care as being excellent and others described their treatment as a shared and informative experience.

The practice had an established Patient Participation Group (a PPG is a voluntary group of patients who work with the practice to improve services) who had produced surveys and reports over the previous 2 years. Action taken as a result of these reports included changes to appointment scheduling, the availability of certain services across the three practice sites and the introduction of on-line prescribing.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure that when significant events are reviewed, any related learning points become a formalised part of the process and are recorded.
- The practice should ensure they keep under review known patient risks for treatment of underactive thyroid, asthma and Lithium monitoring, according to the practices protocol.
- The practice should review their security arrangements for the accounting and recording of prescription pads and access to the branch dispensary.
- The practice should implement a system to check the quality of cleaning undertaken.

Outstanding practice

We saw an area of outstanding practice where the practice had persevered over a few years to establish a regular GP visiting clinic at a traveller site. This proactive approach by the surgery had ensured that patients were registered with a GP practice and had access to primary care. In addition we found that this had prevented unnecessary visits to hospital Accident & Emergency departments.

Longshore Surgeries

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector. The team included two GP specialist advisors, a specialist nurse advisor and an expert by experience. An expert by experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Longshore Surgeries

Longshore Surgeries provides primary medical services from their main surgery in Kessingland and from two branch surgeries in the nearby villages of Wangford and Wrentham. The practice provides a dispensary service and has a registered list of approximately 6,500 patients.

The practice team consists of three male and one female GP partners, three nurses, a health care assistant, a practice manager, a dispensary manager and five dispensing staff and a team of administrative and reception staff. The practice is a training practice for registrar GPs. A GP registrar, or GP trainee, is a qualified doctor who is training to become a GP through a period of working and training in a practice.

The practice has a General Medical Services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice does not provide an out-of-hours service but they have alternative arrangements for patients to be seen when the practice is closed.

Our preparation included discussions with the NHS England Local Area Team (LAT) and the Clinical Commissioning Group (CCG). Both of these organisations commission healthcare services in the area.

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.

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

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

How we carried out this inspection

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?

Detailed findings

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

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

Before inspecting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 08 October 2014 to the main surgery and one branch surgery. During our inspection we spoke with a range of staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, 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 tracked several incidents and saw records had been completed in a timely manner. We reviewed safety records and incident reports and minutes of meetings for the last 12 months. This showed the practice had managed these consistently and could evidence a safe track record for reporting incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, incidents and accidents. We were shown the incident forms that were available on the practice intranet. Once completed, these were sent to the practice manager and to a GP who showed us the system they used to oversee these were managed. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were a standing item on the weekly practice management meeting agenda and a brief written summary had been kept. They had been discussed by the partners and the practice manager only. This system for managing and recording these events did not ensure that potential learning outcomes had been raised and recorded and acted upon and shared with relevant staff. There was however, some evidence from staff that some learning had taken place and that the findings were disseminated verbally and informally to relevant staff.

The dispensary manager had recorded a number of dispensing errors in 2014 which, we were told, were discussed informally within the dispensary department and led to actions and raised awareness about safety. These errors were also discussed at the weekly practice partner meetings with agreed actions to be communicated to staff. Dispensary staff we spoke with confirmed this process of learning.

National patient safety alerts were disseminated as paper copies to relevant practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for.

Policy documents relating to medicine management and dispensing practices were updated on an annual basis and members of staff were informed of any changes.

Reliable safety systems and processes including safeguarding

The provider had policies and systems in place to ensure that patients were safeguarded against the risk of abuse. There was a named GP lead for safeguarding and we saw that all staff had received training appropriate to their role. Effective safeguarding policies and procedures were in place and were fully understood by staff. We saw that information about the local authority's safeguarding process was readily available to staff.

There was close cooperation with the local health visitors which helped to identify children at risk and keep them safe.

There was a written chaperone policy available for all staff and there was a poster on the waiting room wall that explained to patients how to ask for a chaperone and when a chaperone could be appropriate. The practice nurse informed us about the procedure for recording when a chaperone was used. Only the nurses and a health care assistant were used as chaperones, but in the absence of these professionals and in exceptional circumstances members of the reception team were used as chaperones in accordance with the Practice Chaperone Policy. The practice nurses and the HCA were fully aware of the role of the chaperone. One patient told us that they had a chaperone when they had needed a physical examination.

Medicines Management

Policy documents relating to medicine management and dispensing practices were in place and had been updated annually and members of staff were informed of any changes.

We were told that the dispensary at the Wangford branch surgery was sometimes accessed by unaccompanied members of staff who were neither GPs or members of dispensary staff. We discussed this with the senior partner who informed us that this was an occasional occurrence and that the practice staff were always expected to be present.

Good

Are services safe?

Prescription forms were kept securely, but record-keeping practices did not allow them to be fully accounted for, therefore we could not be assured that if blank prescriptions were lost or stolen, this would be promptly identified.

We saw that repeat prescription forms had been signed by GPs before medicines were given to patients.

Medicines for use in an emergency were monitored for expiry and checked regularly for their availability. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the correct temperature for vaccines following their delivery. We checked a sample of controlled drugs and found we could account for them in line with registered records and we noted there were regular controlled drug checks in place.

GPs' bags containing medicines were checked monthly. We saw the four GP' bags at the two branch surgeries had been checked for suitable supplies and for medicine expiry date and were last recorded on 29 September 2014.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. The practice commissioned a cleaner to undertake all cleaning. The cleaner demonstrated that they carried out checks of the quality of their cleaning, although the practice had not implemented their own system to check the quality of cleaning undertaken.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Records showed that all staff received annual infection control training about infection control specific to their role and received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control the risk of cross infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and toilets.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). 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.

We saw records that all staff had received a hepatitis B vaccination apart from the one member of staff employed by the practice to clean the premises. The practice manager said they had risk assesed this role although it had not been recorded. We were informed by the practice manager that this risk assessment would be written immediately.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment that included, weighing scales and the fridge thermometer.

Staffing & Recruitment

The practice had a recruitment policy in place that described the system in place from identifying a vacancy, to a job description through to advertising, interview and selection. It highlighted the need to check experience and qualifications, registration with professional bodies, confirm identity and take up a Disclosure and Barring Service (DBS) check. A DBS check replaced the Criminal Record Bureau check and now includes information from the Independent Safeguarding Authority to ensure people are vetted to enable them to work with vulnerable groups. We looked at staff record that showed that practice had followed their recruitment policy.

The overall staffing levels and skill mix at the practice ensured that sufficient staff were available to maintain a safe level of service to patients without working excessive

Good

Are services safe?

hours. The practice had one full time equivalent GP for every 1650 patients registered with the practice and were providing a sufficient number of appointments for the total number of patients on their list.

The partners and nurses provided a broad mix of specialist areas of knowledge and skills. The specialisms of the clinical team included, cardiology, diabetes, chronic obstructive pulmonary disease and cancer.

Staff we spoke with and information we were shown confirmed that the GPs provided additional cover for each other when any of them were unexpectedly unavailable at short notice.

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. The practice manager explained that this included annual and quarterly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had arrangements for identifying those patients who may be at risk for whatever reason. There were practice registers in place for people in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. Some people in those groups were included in the practice's list for preventing unplanned hospital admissions. The computer system was set up to alert GPs and nurses to patients in these groups and to adults and children who may be at risk due to abuse or neglect.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received annual training in basic life support and use of an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency equipment was available including access to oxygen and an automated external defibrillator. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of 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 for them.

The GPs told us they led in specialist clinical areas such as medicines management, diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital.

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 referred on need and that age, sex and race was not taken into account in this decision-making.

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, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and the IT administrator to support the practice to carry out clinical audits.

We saw clinical audits had been undertaken for asthma inhaler use; returned medication and the use of yellow cards for reporting any side effects of blood thinning medication. Other audits had included those requested by the Clinical Commissioning Group pharmacist. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 90%of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was achieving average or above average for all QOF (or other national) clinical targets.

We found that staff had regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for diabetes. We saw evidence to confirm that following the receipt of an alert shown on the IT system used by the practice, the GPs had reviewed the use of the medicine in question.

We found that the practice did not demonstrate the same consistently proactive system for reviewing known risks to individual patients. Patients' records showed that in the case of an underactive thyroid and patients prescribed warfarin it was not clear who was responsible for monitoring the duration and dosage of the medication or undertaking the reviews. In another patient's record we found their Lithium medication had not been monitored at the three month period that was stated in their notes.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending the mandatory training courses the practice expected of their staff, such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years

Good

Are services effective?

(for example, treatment is effective)

undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

As the practice was a training practice, doctors who were registrars training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from one trainee we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. We saw that specialist nurses worked specifically with patients with certain long term conditions.

We checked the staff training records and saw staff were trained in accordance with their roles and that all training was up to date.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, the administration of vaccines, cervical screening and chlamydia screening.

Data staff told us that patient discharge records were received electronically and in a timely way from the local hospitals, including attendances at A&E departments and from the out of hours service. This information was reviewed daily by the patient's own GP, if their own GP was not available a system was in place to ensure any changes to treatment or medication which may be required was taken.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, 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 a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for 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 which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents, such as those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. Electronic systems were also in place for making referrals. For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. There was a system for making sure test results and other important communications about patients were dealt with. Each GP was allocated their absent colleague's incoming information alphabetically. This meant that all results were seen and there was clarity about which GP was responsible for dealing with them.

The practice also has signed up to the electronic Summary Care Record and had plans to have this fully operational in 2015 (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

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

All members of staff had completed training about information governance to help ensure that information at the practice was dealt with securely with regard to people's rights as to how their information was gathered, used and shared. An in-house messaging system was used for sharing information internally. This provided a clear audit trail for internal messages between members of the team. Staff were alert to the importance of only sharing information with patients, or with patients' consent.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 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.

All clinical staff 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).

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and these plans included a section stating the patient's preferences for treatment and decisions relating to resuscitation should this become necessary.

There was a practice policy for documenting consent for specific interventions such as, minor surgical procedures. Patient's verbal consent had been documented in the electronic patient notes with a record of the risks, benefits and possible complications of the procedure.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room, reception and entrance hall where patients could see them. These included information about Age Concern, cancer care, sexual health contraception, coronary heart disease and drug and alcohol services.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. There was a named nurse responsible for following-up patients who did not attend screening.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and with dementia. The practice had also identified the smoking status of 94% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. Similar mechanisms of identifying at risk groups were used for patients who were obese. These groups were offered further support in line with their needs.

The practice had a programme for patients between 40 and 74 years of age to invite them for NHS health screening checks and provided a cervical screening programme. Clinics for childhood immunisations were held and six week checks were carried out for babies. These clinics were advertised in the practice, in their newsletter and on the practice website.

Flu vaccines and Shingles vaccinations were available for people aged 70 or 79.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction, this included information from the national patient survey and the Patient Participation Group survey carried out for 2013-2014 (a PPG is a voluntary group of patients who work with the practice to improve services). The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 93% of patients had confidence and trust in the last GP they saw or spoke to and 84% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were friendly, efficient and caring. We also spoke with 16 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and common themes were that they were treated with dignity, respect and care.

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 practice answered telephone calls away from the reception area and in a separate office, which helped keep patient information private.

Care planning and involvement in decisions about care and treatment

The patient survey information provided by NHS choices showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 85% said the last GP they saw or spoke to was good at involving them in decisions about their care 86% describe their overall experience of this surgery as good. In the Patient Participatory Group survey 93% of patients said they were satisfied with the medical treatment they received.

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

Some information we received was from patients who were also carers. They described how they had been supported and treated with compassion by the practice team. Other patients also described how they felt they had been well supported emotionally by the practice and had been told about external support services.

When patients died the practice had contacted families to check their well-being and offer them the opportunity to speak with a member of the team. Information was provided about organisations specialising in providing bereavement support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were provided. We saw one outstanding example of how the practice had developed links with a traveller community over time and had been successful in establishing a weekly visit to the traveller site to provide an on-site clinic. Quite often the GP had visited the site more than once each week and had frequently attended emergency call outs. The practice had worked hard to build the trust of this community who may not have had access to a primary care health service.

The practice provided a GP service to a local care home. The home was visited by GPs weekly at which they carried out health checks, medicine reviews, blood tests and any new, or any continuing health issues. The GPs told us they worked closely with staff at the home so that they were able to identify where patients had deteriorated, or had subtle changes in their condition. The home told us a GP did a routine weekly visit to the home as well as visits on other days as needed. They said that it was usually the same GP who visited and that this provided welcome continuity. They told us that the GP was polite, respectful and kind to their patients and listened to them. The home confirmed that the GP had worked with them to review each person's medicines

Patients with learning disabilities were given longer appointments to enable them to have sufficient time to speak with the nurse or GP.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services and there is a plan to have equality and diversity training for all staff in the near future.

Staff told us they offered patients interpreting services if English was not their first language and it became obvious this service would be needed. We saw that the practice policy demonstrated that this service could be requested either over the telephone or face to face.

The premises and services had been adapted to meet the needs of people with disabilities.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Patient had a variety of ways to make requests for repeat prescriptions. These requests were raised by patients by telephone, by repeat slips, or verbally at reception as well as on-line. The practice provided these within 48 hours of the request.

The main surgery was open from 8 am to 6.30 pm, on weekdays and the two branch surgeries were open the same hours, but closed for lunch and for two afternoons each week.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website and how to access care when the surgeries were closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Patients' feedback told us they were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Patients were less satisfied with access to appointments in the longer term. The practice described that sometimes it was not possible for a patient to get an appointment with their named GP at a time of their choice, but they could accommodate appointments with other GPs.

The practice had started to use online communications for patient to order repeat prescriptions, make appointments and to change their personal details and leave messages. Patients were also invited to let the surgery know what they think and could do this on-line or in person at the surgery by completing a survey form.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had needed to make a complaint about the practice.

The practice manager was able to demonstrate how complaints were responded to and a record of all complaints was held, this assisted with the identification of common themes. Concerns had been made known to the practice via the Patient Participation Group that related to the difficulty some patients had accessing appointments. The practice had responded to this and the number of complaints in this area had since reduced.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. These values were clearly displayed in the waiting areas and on the practice website. The members of staff we spoke all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The partners were able to describe how they had responded over the years to changes in policy, legislation and needs of the local population. Examples of this were the way additional clinical staff had been recruited to respond to increased patient numbers and how the practice had responded to feedback to improve access to GPs and had increased the number of appointments available to patients.

Governance Arrangements

The clinical computer system was under used and we saw evidence of some coding and management problems. The partners might find it useful to note there was a need for leadership and training in the use of electronic records and electronic document management.

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. We looked at several of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. Most policies and procedures we looked at had been reviewed although some were overdue their stated review date.

The practice held weekly partners meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their 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 completed a number of clinical audits that included asthma inhaler use, returned medication and anticoagulant cards for warfarin. Other audits had included those requested by the Clinical Commissioning Group for medicines. The GPs told us clinical audits requested by the CCG were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF).

Leadership, openness and transparency

We were informed of the leadership structure which had named members of the GP partnership and nurse staff in lead roles and an executive partner. For example, there was a lead nurse for infection control and one of the partners was the lead for safeguarding. The clinical areas of significant diseases were the responsibility of one named GP under the QOF data collection scheme. This responsibility showed this person was the lead for all of these clinical areas and is a role that the practice might wish to note for shared responsibility.

We spoke with eight members 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 with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. 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.

The practice manager was responsible for human resources, policies and procedures. We reviewed a number of policies, for example, whistleblowing and induction which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, these included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through complaints and through patient surveys. We looked at the results of the annual patient survey and saw as a result the practice had introduced a new appointment system and had also managed to recruit an additional GP.

The dispensary had undertaken its own internal surveys to assess quality and performance. We noted that a patient questionnaire resulted overall in a high return of patient satisfaction. However, the questionnaire indicated some patient comments about the lack of confidentiality when they received their medicines at the reception/dispensary

Are services well-led?

Good

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

area. The Practice had responded to this and a confidentiality notice had been prepared to be displayed in the reception/dispensary area advising patients that they could speak to a member staff in private should they wish.

The practice had an active patient participation group (PPG). The PPG contained representatives from various population groups including older people working age people. The PPG had carried out annual surveys and met periodically with the practice and visited the practice regularly. The results and actions agreed, such as increased appointments, from the PPG surveys were available on the practice website.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training to be given around chaperoning and this had happened.

The practice had a whistle blowing policy which was available to all staff in the written copy of the policy and in the electronic version on any computer within the practice.

Management lead through learning & improvement

The practice was a GP training practice and the senior partner had ensured that this management lead to train newly qualified registrars had inspired the practice in this role. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that annual appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents, such as reported dispensing errors that were discussed at weekly partners meeting with agreed actions disseminated. However, the dispensing manager did not attend these meetings and the clinical lead for dispensing verbally disseminated the actions agreed by the partner GPs. We found that, although the sharing of any learning outcomes as a practice wide process was disseminated verbally, it was not formalised and had not been recorded.