The Orchard Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Orchard Surgery on 22 January 2015.

The practice has an overall rating of good.

The Orchard Surgery provides primary medical services to people living in Lancing, Sompting and East Worthing. At the time of our inspection there were approximately 6,900 patients registered at the practice with a team of two GP partners, a salaried GP, a GP Registrar and a team of nurses.

The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. The practice understood the needs of the local population and engaged effectively with other services. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice was clean and tidy and appropriate hygiene standards were maintained. Emergency procedures were in place to respond to medical emergencies. In the event of an emergency the practice had policies and procedures in place to help with the continued running of the service.

Are services effective?

Good

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

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. During the inspection we witnessed staff interacting with patients in a way that was respectful and friendly. The practice advertised local support groups so that patients could access additional support if required.

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

Summary of findings

local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients. Patients with disabilities were able to easily access the practice. Home visits and telephone consultations were also available.

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 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 and worked closely with the practice. Staff we spoke with told us they felt valued and were appreciated. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.

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. Patients had a named GP which allowed for continuity of care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. Elderly patients with complex care needs all had personalised care plans that were shared with local organisations to facilitate the continuity of care. The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. The GPs followed national guidance for reviewing all aspects of a patient's long term health. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice nurses were trained and experienced to support patients with managing their conditions and preventing deterioration in their health. Diabetic patients were supported by the advanced nurse practitioner who managed their condition but was able to encourage patients to monitor their own condition and set health goals. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Monthly meeting were held with a lead health visitor to discuss any children of concern. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and patients we spoke with on the day of the inspection confirmed this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be seen on the day.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered NHS health-checks and advice for diet and weight reduction. Nurses were trained to offer smoking cessation advice and patients could request routine travel immunisations.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those who were housebound or with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. It offered longer appointments for patients when required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of

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safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Carers and those patients who had carers were flagged on the practice computer system and were signposted to the local carers support team.

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). Patients with severe mental health needs had care plans and received annual physical health check. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. We noted that staff had taken part in a dementia workshop and recently had attended training in the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 4 comment cards which contained positive comments about the practice. We also spoke with nine patients on the day of the inspection.

We reviewed the results of the national patient survey from 2013 which contained the views of 114 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 90% of respondents found it easy to get through to the surgery by phone, 90% said the last GP they saw or spoke with was good at giving them enough time and 94% said they had confidence and trust in the last GP they saw or spoke with. All of these scores were well above the average local Clinical Commissioning Group (CCG).

The practice provided us with a copy of the practice patient survey results from 2014. Results showed that 83% of patients thought they were treated with respect. When asked the question if they felt the GP listened to them 81% said they agreed.

We spoke with nine patients on the day of the inspection and reviewed 4 comment cards completed by patients in the two weeks before the inspection. Both the comments we reviewed and the patients we spoke with were positive about the practice. Comments included that patients felt cared for, respected and two patients commented that staff interacted and explained things well with their children. Comments also included that staff were professional, friendly, caring and they listened to the patients. Some of the patients we spoke with told us they had been registered with the practice for many years and felt the practice had supported them through their health needs and that of their family members.

The Orchard Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead Inspector. The team included a GP, a Practice Nurse and a Practice Manager.

Background to The Orchard Surgery

The Orchard Surgery offers general medical services to the population of Lancing, Sompting and East Worthing. The practice is situated in the centre of Lancing village and is purpose built being managed by an external company. The practice shares its accommodation with staff from the Sussex Community Trust. The practice is involved in the education and training of doctors. There are approximately 6,900 registered patients.

The practice is run by two partner GPs, with one associate GP and a GP registrar (doctor in training). The practice is also supported by an advanced nurse practitioner, two practice nurses and a health care assistant. There is a team of receptionists, administrative staff and an assistant practice manager. At the time of the inspection the practice manager's position was vacant.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and routine holiday vaccinations.

Services are provided from:

Lancing Health
Centre,
Penstone
Park,
Lancing,
West
Sussex,
BN15 9AG

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a slightly higher number of patients between 60 and 85 years of age than the national and local CCG average. The number of patients aged between 05 and 14 years of age were slightly below the national and local CCG average. There are a higher number of patients with long term health conditions and health-related problems in daily life.

The CQC intelligent monitoring placed the practice in band six. 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 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 was meeting the

Detailed findings

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.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Coastal West Sussex Clinical Commissioning Group (CCG). We carried out an announced visit on 22 January 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patients interaction and talked with nine patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 4 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw entered onto the significant events spread sheet a vaccination error that a staff member had raised. Also recorded were the actions taken and the learning outcomes of the incident.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We viewed records of significant events that had occurred during the last 12 months. Significant events were a standing item on the practice meeting agenda where actions and learning points were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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.

Reported events and issues were logged on to a significant events log by the assistant practice manager. The records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, a medicine request via a chemist was found to be incorrect with records showing the patient had already received their medicines. However, after investigating it was found the chemist had not issued the patient with the full required amount of medicines. Learning from this incident re-enforced staff vigilance for repeat prescription requests and that these were being requested at appropriate intervals. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in both safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who this lead was and who to speak with in the practice if they had a safeguarding concern. We saw that a recent safeguarding concern had been recorded onto the significant events log. Staff we spoke with were able to explain how they had raised the concern with the safeguarding lead and had correctly followed the procedure. They commented that this had worked well and as a practice had reflected on the incident.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical

examination or procedure). Nursing staff, including health care assistants, could be required to act as a chaperone and understood their responsibilities, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Staff ensured that medicines stored within refrigerators were kept at the required temperatures, and could describe the action to take in the event of a potential failure.

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. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that the nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, we saw evidence of patients receiving a blood test every three months in line with guidance due to the particular medicine they were taking.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice was in a shared building which had a contract with an external cleaning company. We saw cleaning schedules in place which specified the cleaning requirements and frequencies and completed cleaning records were kept. We observed that this was checked on a regular basis and any issues that had arisen had been brought to the attention of the cleaning company.

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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice was in a shared building and did not undertake its own assessment for legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However, we saw evidence that an assessment had taken place and that regular checks were taken to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and 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; for example weighing scales, spirometers, and blood pressure measuring devices.

Good

Are services safe?

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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 system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. 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.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included 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.

We saw that any risks were discussed at practice meetings and within team meetings. For example, the infection control lead had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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.

An emergency and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, staff shortages and access to the building. The document also contained relevant contact details for staff to refer to. We noted the practice had a mutual aid arrangement with a neighbouring practice. For example, the other practice could help store medicines if the medicines fridge broke down.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

GPs and nurses we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. For example, the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

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 at risk of hospital admissions who had been recently discharged from hospital, which required patients to be reviewed within two days by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

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

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

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of an antibiotic medicine. Following the audit, the GPs carried out a medicine reviews for patients who were prescribed this medicine and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 97% of patients with diabetes had a record of retinal screening in the preceding 12 months. We also noted that 87% of patients with asthma had an asthma review in the preceding 12 months and 94% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional, including an assessment of breathlessness in the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice 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. The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. The practice worked closely with the local pro-active team and created care plans with the patient. (The local pro-active team included district nurses, community matron, physiotherapists, occupations therapists and pharmacists). Patients were also highlighted on the practice computer system so that their care could be prioritised.

The practice also participated in local benchmarking run by the Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example two nurses were being supported to become nurse practitioners. (A nurse practitioner is a registered nurse who has completed advanced coursework and clinical education beyond that required of the registered nurse role). As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Relevant staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw 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 identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register.

Good

Are services effective?

(for example, treatment is effective)

We noted that the practice held monthly palliative care meetings and separate health visitors meetings as well as fortnightly pro-active care meetings. 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. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record EMIS Web, to coordinate, document and manage patients' care. All staff were fully trained on the system. Another software product, DocMan, was integrated with EMIS Web and enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We noted that the practice had attended Mental Capacity Act training and Deprivation of Liberty training in January 2015 and were discussing the practical elements of this with staff members. For example, understanding power of attorney for those who did not have capacity to make decisions to ensure that the best interest of the patient was always considered. GPs and nurses demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with long term conditions and offered an annual physical health check. The practice had also identified the smoking status of 92% of patients over the age of 16 and 90% of those patients had a record of an offer of support and treatment within the preceding 24 months.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was 81%, which was comparable with other practices nationally. There was a mechanism of following up patients who did not attend such as telephone reminders for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the Clinical Commissioning Group, and again there was a clear policy for following up non-attenders.

The practice was taking part in the Year of Care Programme for diabetic patients. Patients were supported by the advanced nurse practitioner who helped manage their condition but was able to encourage patient to monitor their own condition and set health goals. We saw evidence of annual reviews for these patients, together with monitoring of the various markers of their condition including blood tests.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 86% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 89% of practice respondents saying the GP was good at listening to them and 90% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 94% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 91% said the same about the last nurse they saw.

We also reviewed a practice patient survey from 2014 of which the practice. Results showed that 83% of patients thought they were treated with respect. When asked the question if they felt the GP listened to them 81% said they agreed.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all were positive about the service experienced. Patients we spoke with told us they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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.

The reception area was situated on the ground floor with treatment rooms on the first floor which allowed for greater patient confidentiality. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which also helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with senior team members. There was a clearly visible notice stating the practice's zero tolerance for abusive behaviour. Receptionists gave us rare examples where other staff members including the assistant practice manager and GP partner had spoken with patients to help defuse certain situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 81% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were above average compared to the Clinical Commissioning Group area. The results from the practice's own satisfaction survey showed that 80% of patients said they felt the GP explained things well and 78% felt they were given the opportunity to express their concerns or fears.

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.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website also had the functionality to translate the practice information into approximately 90 different languages.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 77% of respondents to the patient participant group survey said they felt the doctors concern for them as a person was good or very good and 78% of patients said they felt reassured by the GP. The patients we spoke with on the day of our inspection were also consistent with this survey information. For example, patients told us they felt staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. Staff told us that they knew patients well and a patient's death was always handled sensitively. The practice would send their condolences to the patient's family and we were informed that some staff members had been invited to funerals.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Staff we spoke with told us that the majority of their older patients were generally mobile and were able to come into the surgery. However, they recognised that local transport for this population group meant that most could not attend the surgery for early morning appointments and had taken this into account when scheduling surgery times. Staff also told us that they were able to arrange Social Services and Occupational Therapy assessments if patients needed additional support in their home.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices 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.

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

For example, patients had commented that they felt uncomfortable placing specimens into the required container whilst it was situated in the waiting room. We noted that the practice had moved the box to outside the toilet which was in a more private area.

Longer appointments were available for patients who needed them and those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Working age patients were able to book appointments and order repeat prescriptions on line. The practice held alternate Wednesday and Thursday late night appointments from 18:30. Patients could also book a Saturday morning appointment, which was run on a rota with neighbouring practices.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice worked closely with the local pro-active care team which included district nurses, community matron, physiotherapists, occupations therapists and pharmacists. Personalised care plans were produced and were used to support patients to remain healthy and in their own homes. Patients with palliative care needs were supported. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term conditions had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required.

We noted that some staff had received equality and diversity training and that there was a policy to support staff. Information was on display for patients in relation to zero tolerance to abuse.

The practice was situated on the first and second floors of a purpose built building. Other than the reception area, services for patients were on the first floor. To gain access to the practice there were doors with an automatic opening mechanism and there was lift access to the first floor. We noted there was a lower section in the reception desk to accommodate patients who used wheelchairs.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Several chairs had arm rests to aid patients when getting up from their seats. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Appointments were available from 8.30am to 1pm and 2pm to 6pm on weekdays. The front desk remained open from 1pm to 2pm for prescription collection and enquiries. Appointments could be booked up to six weeks in advance

Good

Are services responsive to people's needs?

(for example, to feedback?)

and there was extended hours every alternate Wednesday and Thursday from 6.30pm. The practice was also able to offer pre-bookable appointments on a Saturday which was a joint arrangement with other local practices.

There was comprehensive information available to patients about appointments on the practice website and in their practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits could be arranged and GPs visited several local residential and care homes.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor 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. All the patients we spoke with on the day of inspection told us they had been able to get appointments at a time convenient to them. Two patients told us that they had good access to appointments after school for their children. We noted data from the national patient survey 2013 indicated that 95% of respondents said the last appointment they received was convenient**.** On the day of inspection we asked staff when the next available appointment would be for a non-emergency appointment with a particular GP and a cervical screening appointment with the nurse. The appointment system showed that the next (non-urgent) appointment free for both the doctor and nurse would be in just over two weeks.

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.

We saw that information was available to help patients understand the complaints system. We saw that information was in the practice leaflet and on the practice website. However we noticed that there was no information on display in the waiting area. Patients we spoke with told us they would speak with the assistant practice manager or the GP partner if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at seven complaints received in the last 12 months and found these were handled in a timely way with openness and transparency. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 staff we spoke with told us that they felt well led. All the staff we spoke with told us there was a no blame culture in the practice and they felt that senior staff members were always available to talk with. The practice was clinically well led with a core ethos to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose included the statement to provide care and treatment while respecting service users' equality, diversity and human rights and that services would be provided by suitably qualified people in a clean and hygienic environment.

We spoke with 13 members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these. Many of the staff had worked at the practice for a number of years and spoke very positively about the practice. They told us there was good team work and they were actively supported to provide good care for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of the policies and procedures and found they were up to date and held relevant information for staff. This included the confidentiality protocol, infection control and the whistleblowing policy.

The practice had a clinical governance policy which reflected the practice's approach to improve the service to patients and ensure patient and staff safety and well-being. For example, the policy indicated the importance of patient feedback, clinical audits and learning from these, as well as continuing professional development for the practice staff.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice had completed an audit on reviewing the prescribing of a particular medicine used for severe pain relief based on recommendations of the Advisory Council on the Misuse of Drugs. We saw recorded the result of the audit and the conclusion made with actions highlighted. We saw that the audit cycle was yet to be completed with reviews planned for 6 months and one year's time.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a recent risk assessment for infection control and a locum GP who was pregnant.

The practice held regular meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly and there were weekly management / clinical meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time and not just at team meetings. We also noted that the practice held meetings for the entire staff every three months.

We saw that human resource policies and procedures were in place to support staff. Staff told us they had access to a staff handbook and knew where to find these policies if required. We were also shown the on line health and safety policy that was available to all staff, which included sections on stress management, lone working and office safety.

Are services well-led?

Good

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

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, patients comment and complaints received. We looked at the actions from the complaints received. We noted that there had been a complaint regarding the communication skills of one of the GPs. The practice had taken this complaint seriously and the GP had attended a communication course. The GP spoke to us about the course and felt they had benefited greatly by this training and that it had improved their communications skills with patients.

The practice had a virtual patient participation group (PPG) and we saw that the group was advertising for new members on the practice website and through posters in the waiting room. The assistant practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, one of the nurses had recommended that music be played in the waiting area so that patients could not over hear conversations being had in one of the treatment rooms. We noted that this suggestion had been implemented.

All staff were aware of the whistleblowing procedure and we noted that information was on display for staff. There was also a whistleblowing policy which was available to all staff via any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice and supported new registrar doctors in training. At the time of the inspection the practice had one registrar GP. Registrars were supported in their role by experienced, trained GPs and received supervision and mentoring throughout their period in the practice.

Staff we spoke with told us and we saw evidence of protected learning events throughout the year. These were a combination of training designed by the clinical commissioning group (CCG) and internal training / updates from the practice. The practice was closed for these events and patient queries and appointment times were covered by the Out of Hours provider.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, we noted that a significant event had been raised due to a safeguarding concern. We saw that the staff members involved had worked to the correct procedures. The incident was discussed at internal meetings as well with the health visitor to ensure staff were up to date with the processes and to reflect on the situation.