Mid Downs Medical Practice

Quality Report

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Newick
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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 Mid Downs Medical Practice on 26 February 2015. Overall the practice is rated as good.

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

- 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.
- 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.
- Staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Specifically the provider should:-

- Ensure that there is a planned on-going programme for undertaking clinical audits.
- Ensure all staff are familiar with the practice's values and mission statement.
- Ensure that all waste bins in the practice are pedal operated.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Leadership roles were clearly documented and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient reference group (PRG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in avoiding unplanned hospital admissions and end of life care. It was responsive to the needs of older people, and was proactive in meeting their needs. For example it provided outreach flu clinic in the local community and offered home visits for vaccinations if required. The practice worked closely with multidisciplinary teams to ensure support was provided to people in their own homes in order to prevent unplanned hospital admissions.

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 structured annual review to check that 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. For example there was a weekly podiatry clinic at the practice which focused on patients with diabetes and other long term foot conditions.

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. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked closely with midwives, health visitors and school nurses. The health visiting team was based in the practice premises at Newick which helped promote joint working.

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

Summary of findings

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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability and visited them in their own homes.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All people experiencing poor mental health were offered 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. It carried dementia screening on a routine basis. A number of staff had completed on line training to help them understand and support people with dementia. The practice worked closely with the local mental health team which ran clinics from its branch surgery at South Chailey.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14 and a survey of 44 patients undertaken by the practice's patient reference group (PRG) which focused on communication, provision of services and appointment booking. The evidence from all these sources showed patients were satisfied with the service they received. This 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 86.4 % of practice respondents rated the overall experience of their GP surgery as fairly good or very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards which were consistently and strongly positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were friendly, professional and caring. They said staff treated them with dignity and respect. We also spoke with one patient on the day of our inspection. They were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that there is a planned on-going programme for undertaking clinical audits.
- Ensure all staff are familiar with the practice's values and mission statement.
- Ensure that all waste bins in the practice are pedal operated.

Mid Downs Medical Practice

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 specialist advisor and a practice manager specialist advisor.

Background to Mid Downs Medical Practice

The practice is situated in the villages of Newick and South Chailey, near Lewes in East Sussex and provides general medical services to approximately 9150 patients. There are six GPs, three male and three female. The practice also employs two practice nurses, and one health care assistant. Opening hours are Monday to Friday 8.30am until 6.30pm at the Newick Health Centre and 8.30am until 12.30pm and 3.30pm until 6.30pm Monday to Friday at the South Chailey Surgery. The practice also provides extended opening hours on a Saturday morning from 9am until 11am at the Newick Health Centre for pre booked appointments only and evening telephone consultations are available from 6.30 to 7pm Monday to Thursday. The practice provides a wide range of services to patients, including asthma and diabetes clinics, well woman clinics, well man checks, cervical screening, childhood and travel immunisations and cryotherapy. The practice has a contract with NHS England to provide general medical services.

The practice has a higher than average percentage of its population over the age of 65. It also has a lower than average percentage population with income deprivation affecting children.

The practice provides a service to all of its patients at two locations :-

Newick Health Centre

Marbles Road

Newick

Lewes

BN8 4LR

and

South Chailey Surgery

Mill Lane

South Chailey

Lewes

BN8 4PY

Our inspection was undertaken on the practice premises at Newick Health Centre.

The practice has opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services through NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including the High Weald, Lewes and Havens Clinical Commissioning Group (CCG), NHS England and Healthwatch to share what they knew.

During our visit we spoke with a range of staff including, the GPs, the practice manager, the practice nurses, administrative staff and receptionists. We examined practice management policies and procedures. We spoke with a representative from the practices virtual patient reference group (VPRG) and spoke with one patients. We also reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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. There were records of significant events that had occurred during the last year and we were able to review these. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Significant events was a standing item on the weekly practice meeting agenda. There was evidence that actions from past significant events and complaints were reviewed regularly to ensure that learning was implemented. 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.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. The records we looked at were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. National patient safety alerts were disseminated by email to practice staff.

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 lead in 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 of who the GP lead was and who to speak with in the practice if they had a safeguarding concern.

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

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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Most of the receptionists had also undertaken training and understood their responsibilities when acting as chaperones.

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. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

The practice had regular meetings with the pharmaceutical advisor from the clinical commissioning group (CCG). There was evidence that the practice took action in response to reviews of prescribing data undertaken with the CCG.

Good

Are services safe?

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. We saw there were cleaning schedules in place and cleaning records were kept. The patient feedback we received highlighted that they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had a nurse lead and a GP lead for infection control. Training records showed that all staff had received training about infection control specific to their role and received annual updates. We saw evidence that the practice had undertaken an audit of infection control in the last year. The practice had achieved a score of 95% and no areas had been identified for improvement.

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. This included protocols for waste disposal and dealing with biological spillages. We saw that there was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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. However we noted that bins in the staff toilets were not pedal operated.

The practice had arrangements in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed that regular checks were undertaken 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, blood pressure measuring devices and the fridge thermometer.

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. There was 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 annual risk assessment of the practice buildings and environment, a fire risk assessment, work place risk assessments and annual checks of equipment. Identified risks were recorded and there was evidence of action taken as a result of those identified. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

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.

A 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, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the practice's electricity and gas suppliers.

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Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with 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 that guidance from local commissioners was readily accessible via the practice's computer system.

The GPs told us they lead in specialist clinical areas such as diabetes, ear, nose and throat (ENT), muscular-skeletal and minor surgery. The practice nurses supported the GPs on the management of long term conditions, which allowed the practice to focus on specific conditions such as asthma and diabetes. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us they met weekly to discuss complex patients who were difficult to manage and sought advice on the best approach to care and treatment. Learning point form these discussions were recorded in the minutes of the meetings. Consultants from the local hospitals attended these meetings on a regular basis to help improve the knowledge and skills of nurses and GPs and ensure they were up to date with best practice.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

The practice showed us three clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. 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, following drug safety guidance from the MHRA we saw an audit regarding the prescribing of a particular medicine which produced heightened risks of developmental disorders and/or congenital malformations when used by women of child bearing age resulted in a number of patients stopping the medication following appropriate medical advice and counselling. It was noted that clinical audits undertaken in the practice were mainly reactionary and that there was no planned on-going programme of clinical audits.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets and achieved scores above the national average for most indicators. For example, 100% of the practice's patients aged 75 or over with a fragility fracture on or after 1 April 2012, who were currently treated with an appropriate bone-sparing agent.

The practice's prescribing rates were similar to national figures (use data from data pack here).There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and invited them and their relatives and cares to develop a care plan to enable them to be supported as much as possible in their own home. Structured annual reviews were also undertaken for people with long term conditions such as heart failure, diabetes and asthma.

Good

Are services effective?

(for example, treatment is effective)

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The practice regularly analysed data from the CCG for example, on accident and emergency attendances and emergency admissions.

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

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. We looked at the training records for practice nurses which provided evidence that they were trained appropriately to fulfil these duties. For example, we saw that they had attended training on asthma, wound care and paediatrics. All practice staff had a day of protected learning time every three months during which training was provided from the CCG. This included external speakers, for example consultants from the local hospital.

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 held multidisciplinary 'neighbourhood support' meetings every two months to discuss patients with complex need. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those at risk of unplanned hospital admission and patients who need more support to help them stay well in their own homes. These meetings were attended by community nurses, social workers, community psychiatric nurses. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. The practice worked closely with the community matron identifying patients with complex needs to improve compliance with their medical regimes and preventing hospital admission. The practice worked closely with the local mental health team which ran clinics from its branch surgery at South Chailey. The practice also worked closely with the health visiting team which was based on the practice premises at Newick. The close proximity of the team enabled good communication and liaison about children identified as at risk.

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.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. 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. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed GPs gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The practice had recently used the services of and independent mental health advocate (IMCA) to support a patient who lacked capacity to make certain decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

It was practice policy to offer a health check with the GP to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. 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 in line with the national average. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over and the practice was proactive at reaching this group of patients with the provision of outreach flu clinics in the local community and domiciliary visits. The practice provided a smoking cessation clinic and offered a range of screening services including cervical screening. There was a range of patient literature on health promotion, prevention and self-help available for patients in the waiting area. The practice website provided patients with health advice and information about healthy lifestyles.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 203/14 and a survey of 44 patients undertaken by the practice's patient reference group (PRG) which focused on communication, provision of services and appointment booking. The evidence from all these sources 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 86.4 % of practice respondents rated the overall experience of their GP surgery as fairly good or very good. The practice was in line with the national average for its satisfaction scores on consultations with doctors and nurses. For example 85% of practice respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Also 85% of practice respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards which were consistently and strongly positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were friendly, professional and caring. They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. The staff we spoke with demonstrated a good awareness of the practice's policy on maintaining patient confidentiality and were able to give us examples of how they did this in practice, for example offering patients a separate room if they wanted to discuss things in private away from the front desk.

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, 81% of practice respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care and 85% stated that the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions about their care. Patient feedback on the comment cards also highlighted that patients felt listened to and involved in decision making.

Patient/carer support to cope emotionally with care and treatment

The patient 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, 85% of practice respondents to the GP patient survey who stated that the last time they saw or spoke to a GP or nurse, the GP or nurse was good or very good at treating them with care and concern. The comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded with exceptional care, concern and sympathy when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice accommodated the local carers support service who visited fortnightly to see carers and provide a walk in clinic for them. We saw the written information available for carers to ensure they understood the various avenues of support available to them. One of the practice nurses provided a bereavement counselling service to support patients dealing with a bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and 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 to better meet the needs of its population. For example, we saw minutes of regular quality review meetings the practice had with the CCG.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG). For example making it possible to book appointments and order repeat prescriptions on line. The practice had also improved the information it provided on its website about clinics and services including seasonal flu clinics in response to patient feedback.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities as well as appointments at their own homes. The majority of the practice population were English speaking patients but access to translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them for example the practice had recently employed the services of an independent mental health advocate (IMCA).

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The reception desk was lowered at one end for ease of access for wheelchair users and push button front doors to the surgery allowed easy access to the premises. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were male and female GPs in the practice. Therefore patients could choose to see a male or female doctor.

Access to the service

The practices opening hours were Monday to Friday 8.30am until 6.30pm at the Newick Health Centre and 8.30am until 12.30pm and 3.30pm until 6.30pm Monday to Friday at the South Chailey surgery. The practice also provided extended opening hours on a Saturday morning from 9am until 11am at the Newick Health Centre for pre booked appointments only and evening telephone consultations are available from 6.30 to 7pm Monday to Thursday. Patients could make appointments at Newick or South Chailey by telephoning either surgery or they could also book on line. Urgent appointments were available for patients on the same day and routine appointments could be booked up to 6 weeks in advance.

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. 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 more time including older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. Home visits were made to the local residential care homes on a specific day each week, by a named GP and to those patients who needed one. There was also a named GP who saw patients at the local residential facilities for people with learning disabilities.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example data from the national GP survey showed that 70% of the respondents gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone?'. 66% of respondents were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 set out on the website and in a patient leaflet.

We looked at eight complaints received in the last 12 months and found these were satisfactorily handled, and dealt with in a timely way.

The practice reviewed complaints annually 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 and improvements made to the quality of care as a result.

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 recently developed a mission statement to deliver high quality care for patients which was clearly displayed in the waiting areas and in the staff room. However not all staff we spoke with were familiar with the content. We also saw evidence that the practice had developed a one year and five year business plan which was discussed regularly.

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. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice had identified 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. The staff we spoke with 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 GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed regularly at practice meetings and action plans were implemented to maintain or improve outcomes.

The practice had undertaken clinical audits which it used to monitor quality and systems to identify where action should be taken. It was noted however that the practice did not have an on-going programme or plan for clinical audit. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. These included annual risk assessment of the practice buildings and environment, a fire risk assessment, work place risk assessments and annual checks of equipment. Identified risks were recorded and there was evidence of action taken as a result of those identified.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We looked a number of policies, which were in place to support staff. We were shown the staff handbook that was available to all staff in the office areas and on the computer desktop which included sections on disciplinary procedures and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the practice's policy folders and electronically on any computer within the practice.

Leadership, openness and transparency

Staff told us that the partners and manager in the practice were approachable and always take the time to listen to all members of staff. All staff felt involved in discussions about how to run the practice and to share learning.

We saw from minutes that team meetings were held regularly with each staff group. There were weekly meetings for the GPs which the practice nurses could attend. There were also quarterly meetings for administrative and reception staff and for practice nurses. There was a twice yearly meeting for all practice staff. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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 encouraged and valued feedback from patients. It had gathered feedback from patients through the patient reference group (PRG), surveys and complaints received. It had an active PRG which was involved in the development and running of regular patient surveys. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PRG. The results and actions agreed from these surveys are available on the practice website. We spoke with one member of the PRG and they were very positive about the role they played and told us they felt engaged with the practice. (A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 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.