Beech House, Shebbear Surgery

Quality Report

Beech House
Shebbear
Beaworthy
Devon
EX21 5RU
Tel: 01409 2812221
Website: www.shebbearsurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Shebbear Surgery on 16 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services, but found the practice to require improvement for safe services. It was good for providing services for all the population groups.

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.
- 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

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

Importantly, the provider must:

- Ensure all prescriptions for controlled drugs are signed before they are dispensed to the patient.
- Ensure systems are in place to monitor patients that are taking high risk medicines.
- Ensure that the minimum and maximum refrigerator temperatures are recorded to ensure safe storage of medicines.
- Ensure all staff dispensing medication are suitably trained, and their competency reviewed.
- Have a system to record the balance of controlled drugs being received into the dispensary and being dispensed.

In addition the provider should:

- Have systems in place to ensure that medicines used in the case of an emergency are within their expiry date and safe to use.
- Put systems in place to record the room temperature of the dispensary to ensure medicines are stored safely.
- To allow for continuity of care from all healthcare professionals, care plans for vulnerable patients living at a care home should be placed on the practice computer system.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and 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 safeguards in place to identify children and adults in vulnerable circumstances. There was enough staff to keep people safe. Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. The practice was clean, tidy and hygienic. However we found medicines were not stored, managed and dispensed in line with national guidance and there was a breach of the Misuse of Drugs Act as prescriptions for medicines, including controlled drugs, were being given to the patient before being signed by the GP.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data obtained both prior to and during the inspection showed the practice had implemented systems to make sure the practice was effectively run. The practice had a clinical audit system in place and audits had been fully completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. Staff employed at the practice had received appropriate support, training and appraisal. GP appraisals and revalidation of professional qualifications had been completed. There was extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for providing caring services. All patients received 15 minute appointment slots. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect, and ensured confidentiality was maintained.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed and understood the needs of their local population, for example being able to provide heavy goods vehicle (HGV) medical occupational assessments for local farmers. Patients reported that they could access the practice when they needed and the GP was available at the weekends for emergencies. Patients reported that their care was good. The practice was well equipped to treat patients and meet their needs.

There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver quality care and treatment and they were looking for ways to improve. Staff reported an open culture and said they could communicate with senior staff. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care.

The practice had an active patient participation group (PPG) that referred to themselves as friends of the practice. They were involved in some of the decision making processes of the practice.

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 providing care to older people. All patients over 75 years had a named GP. Health checks and promotion were offered to this group of patients. There were safeguards in place to identify adults in vulnerable circumstances.

The practice worked well with external professionals in delivering care to older patients, including end of life care. The GP visited the local care home and the local hospital to review patients care. Home visits from the GP were available at the weekends in emergencies.

Pneumococcal vaccination and shingles vaccinations were provided at the practice for older patients. The practice had achieved 44.39% which was similar to the national average of 52%.

Staff recognised that some older patients required additional help when being referred to other agencies and assisted them with this, for example assisting patients with making hospital appointments.

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions. The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance.

Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes and asthma.

Longer appointments were available for patients if required, such as those with more complex long term conditions.

The practice had a register of patients who were also carers; all carers were offered an appointment for a health check with nursing staff.

Families, children and young people

Good

The practice is rated as good for families, children and young people. Staff worked well with the midwife to provide prenatal and postnatal care. A health visitor visited the practice and worked alongside the GP to provide health surveillance to younger children.

The practice provided baby and child immunisation programmes and ensured babies and children could access a full range of vaccinations and health screening. Data showed that the practice had achieved 90% to 100% in vaccination rates for children up to five years.

Summary of findings

Information relevant to young patients was on display. Health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening, including chlamydia testing and cervical screening.

The GPs training in safeguarding children from abuse was at the required level.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people. The practice provided appointments for patients on the same day, as well as telephone consultations. Emergency appointments were also available. There were extended opening hour's two mornings and one evening a week. Smoking cessation appointments were available. The practice website invited all patients aged between 40 years to 75 years to arrange to have a health check with a nurse.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at team meetings and referral to external services had been made as appropriate, for example a counselling service was available.

The practice did not provide primary care services for patients who were homeless as none were known, however, staff said they would not turn away a patient if they needed primary care and could not access it. Patients with language interpretation requirements were known to the practice and staff knew how to access translation services.

Patients with learning disabilities were offered a health check every year either at the practice or at their own home during which their long term care plans were discussed with them and their carer if appropriate. Reception staff were able to identify vulnerable patients through patient's being flagged on the computer system and offer longer appointment times where needed.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people with poor mental health (including patients with dementia). The practice held a register of patients experiencing poor mental health and there was

evidence they carried out annual health checks for these patients. The practice regularly worked with the multi-disciplinary teams in case management of people experiencing poor mental health, including those with dementia.

The GP, with the district nurses, visited the local care home to carry out fortnightly reviews of the people residing there. Detailed care plans for these clients were kept at the care home and not available on the GP computer system for all staff involved in their care to view.

Staff were aware of the safeguarding principles and GPs and nurses had access to safeguarding policies. The nurses had received training in the Mental Capacity Act (MCA) 2005 and were aware of the principles and had used them when gaining consent.

There was signposting to various local support groups and voluntary organisations including ADACTION and MIND available to patients. The practice referred patients who needed mental health services to specialists and community psychiatric nurses visited the practice to provide treatment and support. Patients suffering poor mental health were offered annual health checks as recommended by national guidelines.

Summary of findings

What people who use the service say

We looked at patient experience feedback from the national GP patient survey from 2014-15. The patient's survey showed the following:

- 93% of the 123 patients that responded found that GPs gave them the time they needed.
- 87% said that GPs were good at explaining treatment and tests to them.
- 87% of patients said that the nursing staff were very helpful and explained their treatment well.
- 95% of the patients found the reception staff helpful.

We spoke with four patients during the inspection. Comment cards had been left in the reception area for patients to fill in before we visited. No comment cards had been completed. One patient visited the practice to speak to us and a representative from the friends of the practice met with us in the afternoon. All their comments were positive.

Patients told us the staff were friendly, they were treated with respect, their care was very good, and they were always able to get an appointment. Of the patients that responded to the national GP patient survey, 100% said that the last appointment they got was convenient.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients were able to get repeat prescriptions from the practice dispensary.

Areas for improvement

Action the service MUST take to improve

- Ensure all prescriptions for controlled drugs are signed before they are dispensed to the patient.
- Ensure systems are in place to monitor patients that are taking high risk medicines.
- Ensure that the maximum and maximum refrigerator temperatures are recorded to ensure safe storage of medicines.
- Have a system to record the balance of controlled drugs being received into the dispensary and being dispensed.
- Ensure all staff dispensing medication are suitably trained, and competencies are being reviewed.

Action the service SHOULD take to improve

• Have systems in place to ensure that medicines used in the case of an emergency are within their expiry date and safe to use.

• Put systems in place to record the room temperature of the dispensary to ensure medicines are stored safely.

• To allow for continuity of care from all healthcare professionals, care plans for vulnerable patients living at a care home should be placed on the practice computer system.

Note: detailed actions will be written in detailed findings section of the report.

Beech House, Shebbear Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, a GP specialist advisor, a pharmacy specialist advisor and a practice manager specialist advisor.

Background to Beech House, Shebbear Surgery

The Shebbear Surgery, also known as Beech House. It provides primary medical services to people living in a rural area of North Devon.

At the time of our inspection there were approximately 1,800 patients registered at the Shebbear Surgery. There were two GP partners, one GP partner had left the practice leaving the senior partner who held managerial and financial responsibility for running the business and they were supported by two salaried GPs, one male and one female who worked two sessions a week and only saw patients in the practice and did not undertake home visits. The GPs were supported by one full time and one part time registered nurse, a phlebotomist [a person trained to take blood], and additional administrative and reception staff. The full time nurse was also the acting practice manager. Patients using the practice also had access to community staff including a podiatrist, district nurses, health visitors, and midwives.

The Shebbear Surgery is open from 8am until 1pm and then 2pm until 6pm Monday to Friday except on Tuesday afternoons when the practice is closed. Patients requiring emergency appointments on a Tuesday afternoon could contact the GP at their second practice in a nearby village. There were extended hour's two mornings and one evening a week. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

The practice also has a dispensary that is open for the same hours as the practice.

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 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.

How we carried out this inspection

Before conducting our announced inspection of the Shebbear Surgery we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Health watch, NHS England, and the local clinical commissioning group.

Detailed findings

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on 16 July 2015. We spoke with four patients, two GPs, two of the nursing team and three of the management and administration team. We also spent time with the dispensary staff. We did not receive any patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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)

Requires improvement

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 and felt able to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last eighteen months. 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 2014/15 and we were able to review these. Significant events were a standing item on the practice meeting agenda. 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.

Staff used incident forms and sent completed forms to the GP. We were shown the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a patient had been given a repeat NHS prescription for a medicine that can only be prescribed on a private prescription by staff in secondary care (secondary care are specialists with specialised knowledge and skills). The practice arranged for this patient to receive their medicine and a meeting was held with all the GPs and dispensing staff to agree protocols for these medicines and lessons were learnt from this.

National patient safety alerts were disseminated by the administrator. Being a small practice these alerts were shared with all staff on the day of receipt and if action was required this was documented and recorded. All alerts were also discussed at practice meetings.

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. 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 GP was the lead in safeguarding vulnerable adults and children. They had been trained to the required level three and could demonstrate they had the necessary training to enable them to fulfil this role. The nurses, reception and administrative staff had been trained to level one. All staff we spoke with were aware 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. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and the nurse had been trained for this role. (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 staff undertaking chaperone duties had criminal records checks through the Disclosure and Barring Service (DBS).

Medicines management

Requires improvement

Are services safe?

Shebbear surgery is a dispensing practice, dispensing medication to approximately 900 of their 1,800 patients. The practice employs a qualified registered pharmacist and an assistant who had not received any accredited training or was currently on any training courses.

We looked at the procedures for storage and safe dispensing of medicines. There were standard operating procedures (SOP) for dispensing in operation, but copies of these were not kept in the dispensary.

We found that there was a lack of systems in place to ensure that appropriate monitoring was in place. Repeat prescriptions were issued and printed in the dispensary and then dispensed and given to the patient without the prescription being signed by a GP, this included controlled drugs. There were no processes in place for signing prescriptions at the end of surgery, this was usually done weekly.

Systems were in place for dispensing repeat prescriptions allowing for 11 prescriptions of medicines to be dispensed before a GP review was required. However we found that high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which required regular monitoring in accordance with national guidance, were also on repeat prescription. The practice nurse told us that this monitoring was undertaken although we found evidence of a patient having been dispensed medicines without the required blood test.

Controlled drugs were stored correctly with only relevant staff having access. We looked at the controlled drugs (CD) book and saw that there were no running balances of CD medicines completed although spot checks were carried out and the balances were correct.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely however access to the keys was not restricted. We found that the practice was not recording the room temperature of the dispensary and the refrigerator used to store medicines did not have a thermometer that could record minimum and maximum temperatures so only actual temperatures were being recorded. The refrigerator was also in need of defrosting.

The practice did not have systems in place to check medicines were within their expiry date and suitable for use. All the medicines we checked within the treatment room were within their expiry dates; however the GP specialist advisor checked the GPs home visit bag and found medicines out of date. These were removed during our inspection. Expired and unwanted medicines were disposed of in line with waste regulations.

Both blank prescription forms for use in printers and those for hand written prescriptions 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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead staff member 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. We saw evidence that the lead had carried out audits monthly and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement 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. Recent training in hand washing techniques had been undertaken. We saw that the modesty curtain in a consultation room had not been changed at the correct frequency of six monthly. There was also 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.

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 diarised records to support this. All portable electrical equipment was routinely tested and displayed stickers indicating the last

testing date, which was in September 2014. 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. These had been calibrated in September 2014.

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). All staff working at the practice had enhanced DBS checks. 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 rota 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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 regular 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.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log.

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 in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a telephone company to contact if the telephones system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills, the last happening in March 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP 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, the implications for the practice's performance and patients 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.

The GP told us that, being the only GP, they were the lead in all areas with specialist clinical areas such as minor surgery, and dermatology. The practice nurse supported this work, which allowed the practice to focus on specific conditions. The part time staff we spoke with were open about asking for and providing colleagues with advice and support.

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.

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 by either a home visit or telephone call to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the GP to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last two years. The GP 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 outcomes of minor operations performed at the practice. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 94.12% of patients with diabetes had an annual foot examination compared to the national average of 88.35%. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and treating patients with osteoporosis (a medical condition in which the bones become brittle and fragile)

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions for example diabetes, and heart conditions.

The GP in the practice undertook minor surgical procedures in line with their registration and NICE guidance. They regularly carried out clinical audits on their results and use that in their learning.

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. The GP was supported by part time salaried staff. One GP partner had

specialism areas in minor surgery and dermatology. 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. The GP partner and practice manager appraised all the administrative staff. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, the nurse told us that they were undertaking the nurse prescriber course.

The practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines. Those with extended roles, for example seeing patients with long term conditions such as asthma and diabetes, were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs, for example those with end of life care needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP 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.

The practice held regular multidisciplinary team meetings weekly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, clinical nurse specialists in palliative care and the community matron. 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 had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice. Staff had accessed MCA training.

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 relevant risks, benefits and complications of the procedure.

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. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff 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.

Health promotion and prevention

It was practice policy to offer a health check with the GP or practice nurse to all new patients registering with the practice and all health concerns detected were followed up in a timely way. We noted a culture among the staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

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 a learning disability and 100% were offered and received an annual physical health check in the past year. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 83.73% which was higher than the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named staff member responsible for following up patients who did not attend screening.

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

A travel consultation service was available. This included a full risk assessment based on the area of travel and used a website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care.

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 patient survey 2014/2015 which demonstrated how the patients and this was with compassion, dignity and respect for example,

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,

- 94% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 93% said the GP gave them enough time compared to the CCG average of 91% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.

We also spoke with four 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. Disposable curtains were provided in consulting rooms and treatment room 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 shielded by glass partitions which helped keep patient information private. The receptionist's desk was situated away from the waiting room. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 95% said they found the receptionists at the practice helpful compared to the CCG average of 91% and national average of 87%.

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 87% of practice respondents said the GP involved them in care decisions which was higher than the national average of 81% and 87% felt the GP was good at explaining treatment and results which was comparable to the national average.

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. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection were also consistent with this survey information. For example, these highlighted 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 were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

Staff told us that if families had suffered bereavement the GP contacted them by telephone. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs. The GP or another staff member also attended the funeral to offer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us they felt well cared for at the practice. Patients we spoke with on the day of the inspection told us they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received or about the staff.

We reviewed the most recent data available for the practice on patient satisfaction. This included a national survey performed in 2014. Evidence from 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 patient survey showed the practice was rated high for all outcomes including consideration, reassurance, and confidence in ability and respect. Patients reported on consultations with doctors and nurses with 90% of practice respondents saying the GP was good at listening to them and 93% saying the GP gave them enough time. These results were above the national averages.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Dignity 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 and 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 at the reception desk behind a glass screen; staff had received training on how to maintain confidentiality whilst conversing on the telephone. We observed this in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. Although to date they had not had patients with a language other than English the practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The practice had level access for patients using wheelchairs and patients with pushchairs. The front door and corridors were wide and all consultation and treatment rooms were on the same floor level allowing easy access for wheelchair users. Toys were available for younger children. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice had the medical equipment it required to provide the services it offered.

Access to the service

Opening times and out of hours arrangements were displayed on the front door of the practice and in all Practice leaflets and relevant posters, practice website, and on NHS Choices website. Appointments were available from 9am to 1pm and then from 2pm until 5pm Monday to Friday except Tuesday afternoons when the practice was closed. There were extended hours on two mornings and one evening a week to accommodate patients that had difficulty accessing the practice during the day.

Patients were able to telephone to pre-book an appointment with a GP and nurse up to ten weeks in advance. Patients were able to telephone the practice to make an appointment on the day with a GP, nurse or health care assistant. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Information was available 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.

Each patient's appointment was allocated 15 minutes and longer appointments were also available for patients who

Good

Are services responsive to people's needs?

(for example, to feedback?)

needed them and those with long-term conditions. This included appointments with the GP or nurse. Home visits were made to a local care home by the GP for those patients who needed one.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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. The GP partner was the responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was displayed as well as information about advocacy services. Complaints forms were readily available on the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

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

Staff were able to describe the vision, values, strategic and operational aims of the practice. Staff said being a small team the main strengths of the practice was the morale and team atmosphere. There were clear lines of accountability and areas of responsibility. Staff knew what their responsibilities were in relation to these.

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

There was a clear leadership structure with named members of staff in lead roles. For example, the nurse was the lead for infection control and the GP was the lead for safeguarding. We spoke with 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 held monthly meetings. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Being a small team staff told us that they could raise any concerns immediately and not wait for meetings.

The acting practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and patients were making reference to areas where improvements could be made, for example email, and more on-line services, the practice was looking into ways of improving these.

The practice had patient participation group (PPG). We met with a member of this group on the day of the inspection and they told us that they called themselves the friends of the practice and that they did not have any concerns. These members were regularly asked to comment on areas where they believed the practice could improve upon the services they deliver. The results and actions agreed from these surveys are available on the practice website. The practice were in the process of requesting patients to become part of a virtual patient group.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. There had been a high turnover of staff since 2014 with only 2 staff remaining pre 2014, they told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management as a good working environment had been developed. Staff 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. We looked at five staff files chosen at random, Four of the files were for the newer staff so appraisal had yet to take place, the staff told us that their induction had been comprehensive and appraisals for a later date had been planned. We saw that appraisals took place which identified training needs. Staff told us that the practice was very supportive of training and there were plans to join up with another practice for training in the future.

Are services well-led?

Good

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

Nursing staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at the nurses' staff file and saw that regular appraisal had taken place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and shared findings with staff both informally and formally at meetings to ensure the practice improved outcomes for patients. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. The results of feedback from patients, through the patient participation group, family and friends test, were also used to improve the quality of services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The proper and safe management of medicines: Policy and procedures should be in line with current legislation and guidance: · Storing, dispensing and preparation · Recording **How the regulation was not being met:** **Regulation 12(2)(g)** All staff dispensing medication were not suitably trained, and competencies were not being reviewed. Maximum and minimum refrigerator temperatures were not being recorded to ensure safe storage of medicines. There were no systems to record the balance of controlled drugs being received into the dispensary and being dispensed. Prescriptions were not being signed before medicines were dispensed to the patient, this included prescriptions for controlled drugs which is also a breach of the Misuse of Drugs Act. · Ensure systems are in place to monitor patients that are taking high risk medicines. · Put systems in place to monitor medicines are within their expiry date within the GP's visit bag.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation (1)(2)(b)**

This section is primarily information for the provider

Requirement notices

Patients on medication, including high risk medicines were not being monitored in a timely way.

Systems were not in place to ensure that medicines stored in treatment room