Minster Surgery

Quality Report

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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 Minster Surgery on 29 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. It was also good for providing services to 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 and people experiencing poor mental health (including people with dementia). It required improvement for providing safe services and the concerns which led to this rating applied to all 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. 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, with the exception of some areas of training that had not been undertaken, although 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.

Summary of findings

- 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.

We saw an area of outstanding practice:

- GPs undertook routine 'mood screening' for all new mothers at post-natal checks and followed-up non-attendance to help ensure signs of depression in new mothers was identified quickly. Double appointments were routinely offered to those patients who had been newly diagnosed with mental health issues.

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

Importantly the provider MUST:

- Provide a safe and effective operating system in relation to preventing, detecting, and controlling the spread of infection, which includes having records and evidence of an audit programme, cleaning activity schedules and appropriate infection control training for staff.
- Provide a safe and effective operating system of recruitment, which includes obtaining DBS checks for administration staff who undertake chaperone duties.

Also, the provider SHOULD:

- review the policy arrangements for safeguarding vulnerable adults
- review the staff training requirements in relation to safeguarding vulnerable adults, chaperone duties, and the Mental Capacity Act 2005
- follow the practice recruitment policy to ensure all checks are in place when staff are employed
- review how risks are recorded, assessed and monitored within the practice.

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 their responsibilities to raise concerns, and to report incidents. When things went wrong, reviews and investigations were undertaken and lessons learned were communicated widely to support improvement. However, there were concerns in relation to how infection control was managed and the training staff had received. There were also concerns in relation to checks that had not been undertaken for staff who carried out chaperone duties.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all GPs and nurses were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients, for example, older people and people suffering from dementia. Data showed that the practice was performing highly in many areas when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes, for example, dementia awareness training for staff, patients and their carers, as well as residents in the community.

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. 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.

The practice acted on suggestions for improvements and responded to feedback from the patient participation group (PPG). It reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) to secure service improvements where these had been identified.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear set of aims and objectives and staff were clear about their responsibilities in relation to these, although these had not been formalised into a written strategy. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular practice / governance meetings. There were systems in place to monitor and improve quality and the practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and worked closely with the GPs and staff to benefit the patients. Staff had received 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 this population group and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice was caring in the support it offered to older people and there were effective treatments and on-going support for those patients identified with complex conditions, such as dementia and conditions associated with end of life care. All patients over the age of 75 had a named GP who was responsible for their care and treatment. A nurse within the practice had lead responsibility for this age group, and was assisted by a health care assistant.

The practice offered an 'out-reach' surgery twice weekly in a neighbouring village to those patients who may have found it difficult to attend the practice, particularly older people, who may have had mobility issues.

Annual influenza vaccinations were routinely offered to older people to help protect them against the virus and associated illness.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice offered nurse led specialist clinics and appointments including asthma, chronic obstructive pulmonary disease (COPD) and diabetes clinics. The practice had systems to alert staff to patients at higher risk of unplanned hospital admissions and they were identified as a priority.

Longer appointments and home visits were available for patients with long-term conditions and annual reviews were arranged to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care.

We saw that influenza vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Summary of findings

Families, children and young people

Good

The practice is rated as good for families, children and young people. Expectant mothers were supported by the midwife linked to the practice who attended for all ante-natal checks. GPs provided full post-natal care and eight week baby checks and were pro-active in undertaking 'mood' screening to pick up signs of depression in new mothers. The practice worked effectively with health visitors and school nurses to provide the care and support required for mothers, babies and children.

The practice offered drop-in clinics for teenagers and young people to provide advice and support in relation to sexual health and contraception.

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.

Working age people (including those recently retired and students)

Good

The practice is rated as good for working age people (including those recently retired and students). The practice had adjusted the services it offered to make them more accessible outside of core working hours. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs of this age group.

The practice offered temporary registration for students who lived away from home during term-time.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for patients whose circumstances may make them vulnerable. The practice was responsive in providing care in patient's homes and provided a regular 'out-reach' surgery for those who found it difficult to attend the practice.

The practice had carried out annual health checks and offered longer appointments if required, for people with a learning disability. The practice supported a local residential home for people with learning disabilities in providing on-going health care and treatment. A health care assistant visited the home on an annual basis to undertake routine health checks and issues were referred to GPs.

The practice worked with multidisciplinary teams in the case management of vulnerable people and offered information about various support groups and voluntary organisations.

Practice staff were aware of their responsibilities regarding information sharing, documentation and reporting in relation to safeguarding concerns and how to contact relevant agencies.

Summary of findings

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice informed patients experiencing poor mental health about how to access various support groups and voluntary organisations and hosted counselling sessions within the practice. It had a system to follow up patients who had attended accident and emergency (A&E) where they may have experienced an episode of poor mental health. Staff had received training on how to care for people with mental health needs and were aware that all patients newly diagnosed with mental health problems required a longer / double appointment for their initial consultation with a GP.

The practice had provided additional training to its entire staff in understanding dementia and had engaged with the community to support local residents to become dementia aware. All practice staff had registered as 'dementia friends' and the patient participation group (PPG) had liaised with the practice and local residents to promote and support a 'dementia friendly village' community.

Summary of findings

What people who use the service say

We spoke with eight patients and reviewed five comment cards completed by patients prior to our inspection. The patients we spoke with were positive about the services they received from the practice and said they felt the care and treatment was good. Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. Patients said referrals to other services for consultations and tests had always been efficient and prompt.

Patients were particularly complimentary about the staff, and said they were always caring, helpful and efficient, and that they were treated with respect and dignity.

Patients told us the appointments system worked well for them and that they would be able to get same day appointments if urgent, although some comments were less positive in relation to getting through to the practice on the telephone in the mornings. All patients told us they always had enough time with the GPs and nurses to discuss their care and treatment thoroughly and never felt rushed.

The comment cards we reviewed were all very positive in all areas, including appointments, staffing and being treated with care and consideration, and having enough time with the GPs and nurses.

The practice had reviewed the results from the national patient survey and was rated well in most areas. This included respondents who would recommend the practice to others, that patients felt involved in decisions about their care, and that the GPs were good at listening to them. Where areas of less satisfaction had been identified, the practice had developed an improvement plan to identify where changes could be made, including a review of the appointments system and the installation of a new telephone system.

Areas for improvement

Action the service MUST take to improve

- Provide a safe and effective operating system in relation to preventing, detecting, and controlling the spread of infection, which includes having records and evidence of an audit programme, cleaning activity schedules and appropriate infection control training for staff.
- Provide a safe and effective operating system of recruitment, which includes obtaining DBS checks for administration staff who undertake chaperone duties.

Action the service SHOULD take to improve

- Review the policy arrangements for safeguarding vulnerable adults.
- Review the staff training requirements in relation to safeguarding vulnerable adults, chaperone duties, and the Mental Capacity Act 2005.
- Follow the practice recruitment policy to ensure all checks are in place when staff are employed.
- Review how risks are recorded, assessed and monitored within the practice.

Outstanding practice

- GPs undertook routine 'mood screening' for all new mothers at post-natal checks and followed-up non-attendance to help ensure signs of depression in new mothers was identified quickly. Double appointments were routinely offered to those patients who had been newly diagnosed with mental health issues.

Minster Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and a pharmacy specialist advisor.

Background to Minster Surgery

Minster Surgery provides medical care Monday to Friday from 8.30am to 6pm each week day and operates extended opening hours until 8.15pm on Monday evenings. The practice is situated in the rural village of Minster, near Ramsgate in Kent and provides a service to approximately 8,000 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. There is a range of patient population groups that use the practice. The practice does not provide out of hours services to its patients and there are arrangements with another provider (the 111 service) to deliver services to patients when the practice is closed.

The practice has three male GP partners, two female GP partners, four female practice nurses, and four female health care assistants. The practice operates a dispensary for patients to collect their medicines and employs five dispensing staff. There are a number of administration / reception and secretarial staff as well as a practice manager. The practice is a GP training practice and two of the GPs take a lead role in the supervision of GP registrars.

The practice has more patients in the newly retired population age group than the national average. There are also a higher number of older people when compared to the national average. The number of patients recognised as suffering deprivation is lower than the local and national averages.

Services are delivered from:

Minster Surgery

75 High Street

Minster

Near Ramsgate

Kent.

CT12 4AB

The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Why we carried out this inspection

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

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

This provider had not received a comprehensive inspection before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 January 2015. During our visit we spoke with a range of staff, including three GPs, one trainee GP (registrar), two dispensary staff, one nurse, seven members of the administration team, and spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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, records of 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. For example, staff had reported and passed on details of a complaint that had been raised by a patient.

We reviewed individual incident reports for the previous year and saw minutes of meetings where these were discussed. We reviewed summarised records for the previous two years. This demonstrated that the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events and we reviewed records of significant events that had occurred during the last year. Significant events were discussed at weekly practice meetings and there was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including reception and administrative staff, knew how to raise an issue for consideration at the meetings and said they felt encouraged to do so.

The practice manager was responsible for managing all significant events and we saw the system used to monitor incidents / events. We tracked two incidents and saw records were completed in a comprehensive and timely manner and that actions were taken as a result. For example, a review of the emergency procedures had been discussed with all staff following an incident where a delay had occurred in requesting an ambulance for a patient who had become unwell. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to staff using the practice email system. A system was used to track all alerts coming into the practice and identified who they were sent to. Records demonstrated that follow-up actions had been taken to address safety issues relevant to the practice, although dispensary staff were not always copied into safety alerts concerning medicines. This was addressed and the process reviewed immediately.

Reliable safety systems and processes including safeguarding

The practice had systems and processes to manage and review risks to vulnerable children. The practice had a policy in relation to the safeguarding arrangements for children, that clearly set out the procedures for staff guidance and contained contact information for referring concerns to external authorities. The practice did not have a policy that set out the arrangements for safeguarding vulnerable adults that reflected the requirements of the local authority protocols for safeguarding vulnerable people. However, when we spoke with staff, they were able to demonstrate awareness of the procedure they would follow to raise any concerns they had.

Staff told us that a GP within the practice was the designated lead in overseeing safeguarding matters and staff were knowledgeable in 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 safeguarding concerns and how to contact the relevant agencies in working hours and out of hours.

Staff told us they had received training in safeguarding vulnerable adults and children and records confirmed administrative staff had received this. The training records reviewed for nursing staff identified that one nurse had not completed the safeguarding training for vulnerable adults and another had not received updated safeguarding training for vulnerable adults since 2004. However, all training records confirmed that training for the protection and safeguarding of children had been completed. Training records for GPs demonstrated they had the necessary training to fulfil their roles in managing safeguarding issues and concerns within the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. 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 GP for safeguarding was aware of vulnerable children and adults and records

demonstrated good liaison with partner agencies such as the police and social services. Every six weeks the practice held a safeguarding meeting, where discussions took place in relation to vulnerable families and patients known to the practice. Issues and concerns raised by the health visitor were also discussed and community nurses would attend when considered necessary. For example, a recent safeguarding concern had been raised by the practice and a meeting was held where social services, community psychiatric nurses and the police had attended.

The practice had a chaperone policy, which set out the arrangements for those patients who wished to have a chaperone (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). Information was available for patients about requesting a chaperone on the practice website and in the patient information leaflet. Staff we spoke with confirmed chaperones were arranged for those patients who requested one. However, training records did not identify that all staff who undertook chaperone duties had received specific chaperone training and the policy did not specify whether this was a requirement of the role.

Medicines management

We checked medicines kept at the practice 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, and 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. Expired and unwanted medicines were disposed of in line with waste regulations.

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

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.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted, although the key pad code had not been changed for some time. Staff confirmed this would be addressed immediately. There were arrangements for the destruction of controlled drugs.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed and we saw this was happening in practice. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for patients to pick up their dispensed prescriptions at another location as well as the practice dispensary, and had systems to monitor how these medicines were collected. They also had arrangements to ensure that patients collecting medicines from this location were given all the relevant information they required.

Cleanliness and infection control

The practice was clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow. For example, hand hygiene, management of sharps and hazardous waste management. There was a designated infection control lead member of staff and they demonstrated an understanding of their role and responsibilities in relation to infection prevention and control. Staff told us that an infection control audit had been undertaken in September 2014 by an external organisation, although the report had not been received by the practice and no records were therefore available to

check if follow-up actions were required. Practice staff confirmed that this would be followed-up, the audit report obtained and reviewed for any issues that needed to be addressed. No previous audit records were available.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. Guidance was displayed in each treatment room for staff to follow in relation to hand washing technique and needle stick injuries. Cleaning records were kept to demonstrate how clinical and medical equipment was cleaned, for example, the spirometry equipment. However, cleaning schedules and records were not kept to identify how treatment rooms and other areas of the practice were cleaned on a daily / weekly basis, including deep cleaning activity. We observed that one of the nurse's rooms had a carpeted floor covering that was stained. Staff told us that occasional wound dressings and blood tests were undertaken in the room and were not sure how frequently the carpet was cleaned. Fabric covered chairs and fabric curtains were used in treatment areas and there was no cleaning regime or schedule to identify the frequency of cleaning or who undertook this.

Regular checks for the detection and management of legionella (a germ found in the environment which can contaminate water systems in buildings) had been carried out at the practice and records confirmed this.

We spoke with staff who told us they had received training in infection control, although training records showed that not all staff had received updated training, for example, two of the nursing staff had not undertaken infection control update training since 2004 and 2008.

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. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment, for example, weighing scales and spirometers.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff, including protocols for checking qualifications, professional registration and obtaining references. Records showed that recruitment checks had been undertaken when employing staff, for example, proof of identification, qualifications and registration checks with the appropriate professional body. However, the staff files examined did not contain documented information in relation to references, as stipulated in the practice recruitment policy. Criminal record checks through the Disclosure and Barring Service (DBS) had been undertaken for the majority of staff, where the practice had considered this appropriate to their roles. However, administration staff had not undergone DBS checks and we were told that on occasions, these staff were required to undertake chaperone duties. Staff told us that the chaperone policy would be reviewed and updated to reflect this requirement with immediate effect and DBS checks would be undertaken for all 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 a system to help ensure that enough staff were on duty and arrangements 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 to keep patients safe. Patients we spoke with told us they felt there were enough staff in the practice to support their care and treatment needs.

Monitoring safety and responding to risk

The practice had a health and safety policy and information was included in the induction plans for new staff. A range of health and safety protocols were displayed for staff guidance, such as fire procedures, handling specimens, and dealing with out of date medicines. Routine annual and monthly checks of the building were undertaken, for example, fire safety checks and legionella tests. However, the fire risk assessment for the building was dated 2008 and had not been reviewed or updated to reflect any changes since that time.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. Emergency referrals were made for patients who had experienced a sudden deterioration or urgent

health problem. We spoke with two patients who had long-term conditions and they described how the practice had responded during routine appointments, when urgent and immediate referrals to hospital had been required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. We spoke with staff who told us about the procedure they would follow to alert other staff that they had an emergency situation in their consultation / treatment room. This enabled them to seek assistance from other staff and the emergency services would be called. We observed a training session at the time of our inspection to help ensure staff were familiar with the procedure to follow.

Records showed that staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with 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 where they were kept. There were processes 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.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, interruption to utilities, or unavailability of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were able to clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing 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 discussed amongst GPs and nursing staff.

The practice used computerised guidance templates embedded into the computer system to ensure GPs and nurses were using up-to-date assessment tools. GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

GPs told us they led in specialist clinical areas such as diabetes, heart conditions and women's health and the practice nurses supported this work which allowed the practice to focus on specific areas of health care, such as contraception.

Management, monitoring and improving outcomes for people

The practice kept registers to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions including dementia, asthma, heart disease and diabetes. The electronic records system contained indicators to alert GPs and nursing staff to specific patient needs and any follow-up actions required, for example, medicine and treatment reviews. Registers were kept under review and we saw meeting minutes where information was shared and discussed regarding the health care needs of specific patients and any additional risk factors that may need to be identified on the system. For example, a register was kept of those patients at risk of unplanned admissions to hospital and a care plan had been developed to help support their needs and avoid unnecessary hospital admissions. All patients over the age of 75 had a named GP who was responsible for their care and treatment and a nurse within the practice was dedicated and had lead responsibility for this age group, and was assisted by a health care assistant.

The practice also had a system to identify and review the care needs of those patients experiencing mental health problems. The practice kept a register of patients experiencing mental health problems and available data showed that 91% of these patients had a comprehensive care plan that had been agreed in the last 12 months, compared to 86% nationally. Of these patients, 92% also had their alcohol consumption recorded in the last 12 months, compared to 88% nationally. Patients experiencing mental health problems who had attended accident and emergency (A&E) departments were discussed at the weekly practice meetings and followed up by the GPs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw Quality and Outcomes Framework (QOF) data that indicated multi-disciplinary review meetings were held at least every three months to discuss all patients on the register. QOF is a national performance measurement tool used by GP practices to measure and compare their performance to other practices on a local and national basis.

Data collected for the QOF was reviewed at clinical meetings where information was shared and discussed amongst relevant staff to monitor performance. The available QOF data showed that the practice had many indicators that were higher than the national averages, including clinical indicators that were considerably higher in all areas for patients receiving care and treatment for diabetes. For example, 97% of patients with diabetes had received a foot examination in the last 12 months, compared to 88% nationally. Of these patients, 99% had also received an annual influenza vaccination, compared to 93% nationally. The practice had achieved 99% of the total QOF target in 2014, which was above the national average of 96%.

The practice had a system for completing clinical audits. We saw that clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. For example, we saw that an audit had been undertaken to consider the reasons for a higher than expected prevalence of hypertension (raised blood pressure) in patients placed on the register, when compared to other practices in the locality. The results showed that in the patient records audited, the practice was following appropriate diagnostic criteria, although the audit revealed that the protocol for placing patients on the

Good

Are services effective?

(for example, treatment is effective)

register and the treatment regime could be made clearer. Some changes had subsequently been made to administrative processes to help ensure that computer codes were applied accurately when using the QOF system. The practice protocol had also been updated to help illustrate and clarify the treatment regimes for patients with hypertension. A second audit was later completed to review the impact of these changes and it was found that patients had been placed appropriately on the register and the correct protocol had been followed in diagnosing and treating their conditions. Other recent audits had also been completed, for example, to review patients with gestational diabetes, patients with atrial fibrillation and a records management audit in relation to contraception. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

An audit had also been initiated by the lead GP for dementia, to review dementia diagnosis within the practice, as the QOF data indicated a lower prevalence than expected. Since completion of the audit, the practice had identified a trend of increased diagnosis. For example, a number of patients had been identified for recall to the practice to review their diagnosis and some patients had already been contacted and were undergoing further assessment and included in the dementia care pathway.

The practice had also introduced a range of training initiatives to raise awareness for staff in relation to dementia care and support. For example, the lead GP had undertaken a three-day dementia training workshop and all staff within the practice, including administration staff, had received a number of dedicated dementia awareness training sessions and had registered as 'dementia friends'. This had been recognised by the practice and staff wore badges to acknowledge this. The benefits to patients included a wider recognition and understanding of the staff team, in supporting patients' needs in the most effective ways.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and the computer system provided an alert for those patients who required a medicines review.

Effective staffing

The practice staff team included GPs, nurses, managerial and administrative staff. Staff told us they had completed some mandatory training, for example, basic life support and we saw records that confirmed this. However, some mandatory training required updating, including safeguarding vulnerable adults, infection control and chaperone training for some staff. We saw that GPs and nurses had completed specialist clinical training appropriate to their roles, for example, diabetes, asthma, family planning and updates in childhood immunisations.

Staff we spoke with confirmed that the practice was proactive in providing training, for example, e-learning on the practice computer system was available and undertaken on a regular basis. The practice closed for training one afternoon each month, to provide in-house opportunities for staff learning and development.

As the practice was a training practice, doctors who were in training to become qualified GPs had access to a senior GP throughout the day for support.

We were told by staff that they received annual appraisals where training needs were discussed and additional learning identified, and we saw records that confirmed this. All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. A process for GP appraisal and revalidation was in place and we saw that dates were confirmed for annual appraisal and completion of revalidation for each GP within the practice. (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).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these roles, for example, administration of vaccines and cervical cytology. Those with extended roles, who supported 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 had well established processes for multidisciplinary working with other health care professionals and partner agencies. GPs and nurses told us that these processes ensured that links remained effective with community and specialist nurses, to promote patient care, welfare and safety. For example, GPs and nurses

attended six weekly multidisciplinary meetings that included specialist community nurses and the palliative care team who had specialist knowledge in long-term and complex conditions. These meetings also included regular attendance from the health visitor and the school nurses to discuss families and patients where there were concerns in relation to safeguarding.

The practice held midwifery and health visitor clinics to provide ante-natal care, support for new mothers and babies and to undertake full post-natal and eight week baby checks. The practice worked with external counsellors and mental health specialists to provide counselling sessions at the practice for those patients experiencing poor mental health.

The practice received blood test results, x-ray results, and letters from the local hospital (including discharge summaries), out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures for staff to follow in relation to passing information on, as well as reading and acting on any issues arising from communications with other care providers on the day that 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 worked well.

Information sharing

Staff told us that there were effective systems to ensure that patient information was shared with other service providers and that recognised protocols were followed. For example, a referral system was used to liaise with the community nurses and other health care professionals, including the 'out of hours' service. The practice used the 'Choose and Book' referral system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

An electronic patient record system was used by staff to co-ordinate, document and manage patients' care. Staff were fully trained in how to use the system and told us that it worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future use or reference.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how consent should be recorded. For example, forms were used to gain the written consent of patients when undergoing minor operations.

We spoke with nursing staff and GPs, who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment. They told us that mental capacity assessments were carried out by the GPs and recorded on individual patient records. Although formal training in the Mental Capacity Act 2005 had not been undertaken, staff had received dementia training. They were able to demonstrate their awareness and gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision and required additional support.

The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff.

Health promotion and prevention

Staff told us about the process for informing patients who needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us they were contacted by the practice to attend routine checks and follow-up appointments.

We saw a range of information leaflets and posters in the waiting area for patients, informing them about the practice and promoting healthy lifestyles, for example, smoking cessation and weight loss programmes. Information about how to access other health care services was also displayed to help patients access the services they needed, for example, sexual health, including chlamydia testing.

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, cervical smear screening and general health checks including weight and blood pressure monitoring.

Good

Are services effective?

(for example, treatment is effective)

We spoke with nursing staff who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes, asthma, epilepsy and coronary heart disease. All new patients who registered with the practice were offered a consultation with one of the nurses to assess their health care needs and identify any concerns or risk factors that were then referred to the GPs.

The practice had systems to identify patients who required additional support and were pro-active in offering additional services for specific patient groups. For example, vaccination clinics were promoted and held at the practice, including a seasonal flu vaccination for older people. Annual NHS health checks were offered to patients aged between 40 and 75 using national guidance, to identify health issues that required follow-up or further investigation. GPs undertook routine 'mood screening' for all new mothers at post-natal checks and followed-up non-attendance to help ensure signs of depression in new mothers was identified quickly.

The practice kept a register of patients who had a learning disability and promoted / encouraged annual health checks for these patients. For example, the practice supported a local residential home for people with learning disabilities in providing on-going health care and treatment. A health care assistant from the practice visited the home on an annual basis to undertake routine blood tests and health checks. Where issues or risks to health were identified, GPs from the practice would undertake follow-up visits to help ensure on-going health care needs were supported and appropriate treatment provided.

The practice offered a full range of immunisations for children and travel vaccines. Last year's performance for childhood immunisations was either in line or above average for the CCG area and there were systems to follow-up non-attenders. For example, data showed that 99% of 5 year olds had received the meningitis vaccination, compared to 91% nationally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice in relation to patient satisfaction. Information from the national patient survey undertaken in 2013/14 showed that the practice had been rated above or in line with the national average in most areas. For example, 90% of patients responding to the survey rated the practice GPs as good or very good at treating them with care and concern, compared with 85% nationally. The practice was also rated well above average for its satisfaction scores on consultations with doctors and nurses, with 92% of respondents saying the GPs were good at listening to them.

Patients completed comment cards to provide us with feedback about the practice. We received five completed cards and they were all positive about the service experienced. Patients commented that the practice offered an excellent service, all staff were helpful, caring and considerate in their approach. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided and that the practice was very caring. There were some comments in relation to difficulties in getting through to the practice on the telephone in the mornings, although other patients felt this was not a problem. Reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support patients with their requests.

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

The practice had a confidentiality policy, which detailed how staff protected patients' confidentiality and personal information. Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality and the policy had been shared with them. The reception area was designed in a way to help maintain confidentiality when staff were speaking on the telephone. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed there had been a positive response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 89% of respondents said GPs were good or very good in involving them in decisions about their care, compared to 82% nationally. Similarly, 88% of respondents said that nurses were good or very good at involving them, compared to 85% nationally.

When we spoke with patients, they told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options available to them and that they felt included in their consultations. They felt able to ask questions if they had any and were able to change their mind about treatment options if they wanted to. Similarly, when we reviewed the comment cards patients had completed prior to our inspection, patients stated that they were listened to, their questions were answered and that staff responded well to their needs.

The practice had developed care plans to support those patients with long-term conditions / complex needs and patients told us they had been involved in developing their care plan with the practice GPs and / or nurses and were aware of the treatment regimes that had been agreed.

There was a range of leaflets and posters in the waiting room that provided patients with information about health care services. For example, information about the practice and the services it offered, the promotion of healthy lifestyle choices and contact details of other services and support that patients may have found useful. Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the support they needed and that they felt able to discuss any concerns or worries they had.

We saw that patient information leaflets, posters and notices were displayed that provided contact details for specialist groups that offered emotional and confidential support to patients and carers. For example, a counselling and bereavement support group, as well as counselling sessions that were offered at the practice. The practice's electronic system alerted GPs if a patient was also a carer. We saw a range of information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time, but in most cases the GP visited the bereaved patient in their own home.

The practice was situated in a rural location and provided health care services and support to the village population. This engendered a community ethos of care and concern amongst the residents in supporting each other. As such, the practice had been approached by members of the community to raise awareness and understanding to the problems and challenges experienced by local residents suffering from dementia. In this respect, the practice had developed links and engaged with the community to provide training / awareness sessions based at the practice for their own staff and local residents to become 'dementia friends'. Although this initiative had originated from the local community, including the support of local businesses, the practice had provided the venue to promote and support a shared commitment with the local population to become a 'dementia friendly village'. When we spoke with staff, they described the benefits they felt this had brought to patients and their families / carers in being supported and cared for by staff who had insight and understanding of their condition and could respond in the most appropriate ways to meet their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs and there were systems to address the identified needs of the patient population group in the way services were provided. This included regular engagement with the area clinical commissioning group (CCG) and other practices within the locality to consider and review local service needs. The practice had a lead GP who was a member of the CCG governance board and attended regular meetings to represent the practice. The practice manager and senior nurse also attended CCG steering groups on a regular basis to share information and consider best practice initiatives.

The staff we spoke with explained that a range of services were available to support and meet the needs of different patient population groups and that there were systems to refer patients to other services and support if required. For example, referring mothers with babies and young children to the community health visitor and older people to specialist groups who supported people with dementia and associated physical problems. Patients we spoke with told us they were referred promptly to other services for treatment and test results were available quickly.

The practice had also considered suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We spoke with a representative from the group who described how the practice worked with the PPG to help improve services for patients. The PPG had undertaken patient surveys in the past, focusing on specific issues or topics, for example, seeking feedback from patients in relation to the car parking arrangements at the practice. The results had been collated and revealed that the majority of patients felt that improvements to the car park would be beneficial. The practice had therefore investigated the costs and received quotations for external building works that would be required, although a final decision had not been made.

The PPG had established strong links with the local community and produced a practice newsletter each month that was delivered to all residents in the locality with the parish magazine. The local community had advocated that fund raising activity should be a key focus for the PPG to improve the facilities and equipment at the practice. Regular fund raising events were therefore held, supported by the residents and businesses within the local area. The practice had used the funds to purchase additional equipment, for example, blood pressure and heart monitoring equipment. Details were displayed in the patients' waiting area about the funds already raised, the next key target and the decisions made by the patients about how the funds would be spent. The PPG newsletter and the practice website also contained this information. The PPG had also arranged training to be undertaken with NHS specialists for practice staff.

Tackling inequity and promoting equality

The practice was located in purpose-built premises and there was easy access to the treatment and consultation rooms that were all located on the ground floor. The waiting area was large enough to accommodate patients with wheelchairs and prams and accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had a hearing loop system for patients who had hearing difficulties and interpretation services were available by arrangement for patients who did not speak English. Parking spaces had been provided for patients who had a disability.

The practice had a policy regarding equality and diversity and took account of the needs of different patients in promoting equality and considered those who may be in vulnerable circumstances. Although staff had not received formal equality and diversity training, they were able to demonstrate an awareness of the needs of different patient groups. For example, identifying those patients with learning disabilities to help ensure they received appropriate care and support, including an annual assessment of their health care needs.

Access to the service

Appointments were available from 8.30am to 12 noon and from 3pm to 6pm each week day, although calls were taken throughout the day and a GP was available. The practice operated extended opening hours until 8.15pm on Monday evenings, which provided flexibility for working patients outside of core working hours. Staff we spoke with were knowledgeable about prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was in a rural location and many of their patients consequently lived in surrounding rural villages. To enable wider and easier access to the services, the practice offered an 'out-reach' surgery twice weekly to patients who lived in a neighbouring village, where a GP, a medicines dispenser and a member of the administration staff attended a community village hall. The practice had found this was particularly useful for those patients who were less mobile, who would otherwise find it difficult to attend the practice. Home visits were available on a daily basis for those patients less able to attend the practice and co-ordination with the community nurses enabled patients to have blood tests at home. Specialist external health care services were also 'hosted' at the practice, for example, physiotherapy and counselling clinics, to provide easier access to care services that were closer to patients' homes, given the rural location.

Patients could book an appointment by telephone, online or in person. Most of the patients we spoke with said that the appointments system worked well for them. Patients told us that they could have telephone consultations and that the GPs were very good at calling them back if requested. The GPs we spoke with confirmed that same day telephone consultations were offered to all patients and this was managed via the electronic communication system.

Patients we spoke with and comments we received all expressed confidence that urgent problems or medical emergencies would be dealt with promptly and that staff knew how to prioritise appointments for them. For example, the practice had a system to identify and prioritise patients at risk of unplanned hospital admissions to help ensure they had urgent access to a GP appointment. One patient we spoke with described an occasion when they had requested an urgent appointment for their child. They said that even though there were no appointments available, they had been asked to come to the practice straight away and a GP had seen them. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment, if they needed an appointment or how the GPs would decide to support them in other ways, for example, a telephone consultation or home visit. The practice also offered pre-bookable appointments and online appointment bookings.

Patients told us they could always request longer appointments if they needed them, particularly if they had long-term conditions or complex health care needs. Double appointments were routinely offered to those patients who had been newly diagnosed with mental health issues. The practice was flexible in supporting local residents who were not registered at the practice. For example, offering temporary registration for students who lived away from home during term-time. The practice also offered 'drop-in' clinics for teenagers and young people to provide advice and support in relation to sexual health and contraception.

There were arrangements to ensure patients could access urgent or emergency treatment when the practice was closed. Information about the 'out of hours' service was displayed inside and outside the practice and was also included in the patient information booklet and on the practice website. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. The practice had a complaints policy that was in line with NHS guidance for GPs and 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. The procedure was included in the practice information booklet and on the practice website, although this had not been displayed in the patient waiting / reception area. We looked at six complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way and in accordance with the practice policy.

The practice reviewed complaints on an annual basis to detect themes or trends. The summary report for the previous year had been discussed at practice meetings to review any changes that could be made and we saw that these were acted on. For example, some communication issues had been identified and the management team had reminded staff about the importance of effective communication with patients and following practice procedures at all times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with told us that they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to do so.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a 'statement of purpose' that clearly set out the aims and objectives of the practice to provide safe, effective, high quality care to its patients. When speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose. The practice statement expressed an ethos of mutual respect, holistic care, continuity of care and a commitment to learning and training.

Governance arrangements

The practice had a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding, dementia, diabetes, cardiology and medicines management. A senior nurse led the nursing team within the practice. We spoke with eleven members of staff who were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns or issues.

The practice held weekly meetings that were structured to provide a six weekly rolling programme that covered key governance / management topics for discussion. For example, safeguarding, critical incidents / events, medicines management, as well as clinical governance and we saw examples of the minutes from these meetings. Reviews and outcomes from clinical audits were also discussed, as well as information and analysis of the Quality and Outcomes Framework (QOF), to enable the practice to monitor on-going performance. We saw QOF data that indicated the practice was performing above national standards in many areas and the overall QOF achievement for 2014 had also been higher than the national average. Where the data indicated concerns, the practice had taken action to improve performance, for example, dementia assessment and diagnosis.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit to review the medicines prescribed for those patients with a particular heart condition and the results had been used to check GP prescribing regimes.

The practice had a number of policies and procedures to govern activity and these were available to staff on any computer within the practice. We looked at ten of these and saw that they had been reviewed annually and were up to date.

The practice had limited arrangements in place for recording and managing routine risks in relation to the premises and its staff. Although some risk assessments had been undertaken, for example, a fire risk assessment, this had not been reviewed or updated on a regular basis. There were also concerns regarding the management and assessment of risks in relation to infection control and DBS checks for staff who undertook chaperone duties.

Leadership, openness and transparency

We spoke with the practice GPs who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us they felt there was an 'open door' culture, the GPs were approachable, they felt supported and were able to approach the senior staff about any concerns they had. They said there was a good sense of team work within the practice and communication worked well. All staff said they felt their views and opinions were valued. They told us they were positively encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients.

The practice manager was responsible for the implementation of human resource policies and procedures. We reviewed a number of these, for example, sickness absence, bullying and harassment policies, which supported 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, comment cards, complaints and questionnaires. The most recent national patient survey had rated the practice less well in relation to patients seeing the GP of their choice. Following the results of the survey the practice had developed an improvement plan that included a review of the appointments system and a planned permanent increase to the GP hours available at the practice. The plan also included an upgrade to the practice telephone system in response to patient feedback.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG attended and met with the practice regularly. It had formed strong links with the local community, where it represented the practice at local events and fund raising activities. The PPG members and practice staff worked closely together, led by the GP partners, in raising funds for additional equipment and had provided additional training to all the staff in understanding dementia, as well as engaging with the community to support local residents to become dementia aware. All practice staff had registered as 'dementia friends' and the PPG had liaised with the practice and local residents to establish a 'dementia friendly village', which promoted a supportive and inclusive approach to patients' care needs.

The practice had gathered feedback from staff through discussions, appraisals and generally through staff meetings. All the staff we spoke with told us they had opportunities to comment and suggest ways of making improvements to the services. Staff told us they felt involved and engaged with the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Records showed that GPs and nursing staff were supported to access on-going learning to improve their clinical skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. Staff said they had protected time set aside for learning and development, for example, monthly half-day closure of the practice to undertake training and development. We saw that formal appraisals were undertaken to monitor and review performance, and to identify training requirements. However, the practice had not completed a training audit to help ensure some areas of mandatory training for staff were kept up-to-date.

The practice was a training practice and there were four trainee GP registrars who had placements there. All GPs and nurses were to some degree involved in the training of future GPs, although two of the GPs at the practice had lead roles. The practice was therefore subject to scrutiny by Health Education Kent, Surrey and Sussex (called the Deanery). Trainee GPs were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings to help ensure the practice improved outcomes for patients. For example, a recent significant event had resulted in a review of the procedure for urine testing.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users in relation to assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated, because the staff employed to carry on the regulated activities had not received updated infection control training, the provider did not have an infection control audit programme and there were no cleaning activity schedules kept. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(1)(2)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not have established recruitment procedures that operated effectively to ensure that information was available in relation to each person employed for the carrying on of the regulated activities, because the provider had not undertaken Disclosure and Barring Service (DBS) checks for staff who undertook chaperone duties. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19(3)(a) – Schedule 3