Drs Shorney, Twomey, Murphy, Braddick and Griffiths

Quality Report

Chiddenbrook Surgery
Threshers
Crediton
Devon
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Website: http://www.chiddenbrook-surgery.nhs.uk/index.aspx

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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 Chiddenbrook Practice on 25 November 2014. This was a comprehensive inspection. The practice is based at Chiddenbrook Surgery and provides primary medical services to people living in the town of Credition and surrounding villages in Devon covering approximately 250 square miles. The practice provides services to a diverse population.

At the time of our inspection there were 7334 patients registered at the service with a team of six GP partners. GP partners held managerial and financial responsibility for running the business. In addition there was three registered nurses, two healthcare assistants, a phlebotomist, a practice manager, thirteen administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Overall the practice is rated as good.

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

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- 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.

Summary of findings

- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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. Urgent appointments were available the same day and staff were flexible and found same day gaps for patients needing routine appointments.
- 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.
- There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients nearing the end of their lives. This included proactive management of emergency and short term pain relief medicine to counteract access to very limited out of hours pharmacist services in the practice area. This enabled carers to avoid having to travel long distances for these medicines.

We saw areas of outstanding practice:

- The practice had invested in various specialist equipment to facilitate early diagnosis and treatment. For example, equipment to diagnose the risk of deep vein thrombosis was being used, which meant patients could be diagnosed and treated quickly to reduce further health risks from developing. Patients with long term conditions were benefitting from specialist equipment that had been purchased so that blood screening was carried out at the practice for patients. For example, patients on blood thinning medicines needed regular blood testing to reduce potential risks to their health and ensure the dose was appropriate. Normally blood testing was done at the local hospital with results available the following day. However, the equipment that the practice had purchased meant that patient blood samples could be analysed and results were available immediately and discussed with patients. Immediate changes to their medicine dose could then be made in response and additional advice and support given where needed.
- The practice took an early intervention approach and had set up an educational programme for patients at risk of developing diabetes. This was run over a course of sessions in the evenings and helped patients change their lifestyles through the weight management or smoking cessation programmes where further advice and support was provided. Data showed 97% of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%.
- Vulnerable patients were referred to an innovative and successful community service, which engaged isolated adults in a rural area through stimulating, creative and social activities. A GP at the practice was one of the founding members and an active partner in this community service. The practice was also actively involved in the development of a community hub service in Crediton in partnership with other agencies.

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

Importantly the provider must

- Ensure that patients are protected by gathering and reviewing the information in relation to people working at the practice. This concerns the recruitment of staff and the personnel information required including proof of identity, qualifications, employment history and relevant criminal record checks are carried out, if necessary to the role, and the relevant information retained as required by the legislation.

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 to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff, however recruitment practices were not consistently followed and did not ensure staff were fit to work at the practice or safe to carry out chaperone duties.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams, which included strong links with other health and social care professionals supporting patients at the end of their lives.

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. Staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Summary of findings

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was reviewed and acted upon.

Are services well-led?

Good

The practice is rated as good for being well-led.

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

Patients with complex care needs were well monitored by the practice working in partnership with other agencies. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Information systems enabled the practice to share important clinical and social information about patients with complex needs. This facilitated continuity of care for those patients.

There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients nearing the end of their lives. Patients were experiencing proactive management of emergency and short term pain relief medicine, which helped carers avoid having to travel long distances for these medicines.

Pneumococcal vaccination was provided at the practice for older people. In 2014, the practice had run two Saturday flu clinics as well as the standard week day appointments. Shingles vaccinations were also provided to patients who fit the age criteria. Patients were contacted to offer them the opportunity to make an appointment to have the vaccination.

The practice was working closely with the CCG and community to develop a health and social hub which will provide services to support the older population. Services proposed include day centre facilities, a memory cafe, balance classes, nail cutting and bathing services.

The practice provides space for regular carers clinics and works with a community support worker to provide additional help for carers.

People with long term conditions

Good

The practice is rated as outstanding for the care of people with long-term conditions.

Nursing staff had lead roles in chronic disease management and had dedicated appointments to review patients with diabetes, asthma and/or chronic respiratory disease. patients at risk of hospital

admission were identified as a priority. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice held multidisciplinary meetings every month to review the needs of all patients with complex long term conditions.

Longer appointments and home visits were available when needed. Home visits for patients newly discharged from hospital were undertaken jointly with the community nursing team to carryout an assessment and arrange additional support where needed.

The practice had invested in various specialist equipment. Patients with long term conditions were benefitting from specialist equipment that had been purchased so that blood screening was carried out at the practice for patients. Patients on blood thinning medicines needed regular blood testing to reduce potential risks to their health and ensure the dose was appropriate. Normally blood testing was done at the local hospital with results available the following day. However, the equipment that the practice had purchased meant that patient blood samples could be analysed and results were available immediately and discussed with patients. Immediate changes to their medicine dose could then be made in response and additional advice and support given where needed.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be taken at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by patients we spoke with who were in this position as it avoided them having to travel to the opthalmology clinic based at the main hospital approximately 10 miles away

The practice had links with the external health care professionals to provide advice and guidance as required. GPs and/or nurses from the practice attended quarterly a virtual Diabetic clinic with hospital specialists to review patient care and treatment.

Health education around diet and lifestyle was promoted by the practice. The practice took an early intervention approach and had set up an educational programme for patients at risk of developing diabetes. Sessions were run in the evenings for patients. This helped patients change their lifestyles through the weight management or smoking cessation programmes where further advice and support was provided.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The waiting room had a separate child friendly play area, with handmade toys and a playhouse to occupy children whilst they were waiting for their appointment.

Emergency processes were in place for acutely ill children, young people and acute pregnancy complications.

The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance. For example, a breast feeding advisor used a private room to support and teach new mother's to breast feed their babies. Another example was the close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided. The practice provided information about contraception for young people. GPs had strategies in place to avoid giving mixed messages to young people about contraception and other health matters. The practice offered advice and carried out confidential chlamydia screening.

Support was being accessed for parents from children's workers and parenting support groups where relevant.

The practice was proactive in getting feedback from patients and the patient participation group included parents with young families.

All 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. Close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided. The practice provided information about contraception for young people. GPs told us that they took a team approach by discussing

situations with each other at a lunchtime meeting each day. They told us this then avoided mixed messages being given to young people about contraception and other health matters. The practice offered advice and carried out confidential chlamydia screening.

Parents with children attending the practice confirmed that they were always present during consultations. They told us that all of the staff spoke to their child at their level and helped to reduce any anxiety they might be feeling.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example, appointments could be booked up to 2 weeks in advance for a GP and up to one month for a nurse. Early morning and evening appointments were available. Patients could request repeat prescriptions online, via email, the local pharmacy or in person at the practice. Repeat prescriptions were being given for up to six months.

Overseas travel advice including up-to-date vaccinations and anti-malarial drugs was available from the nursing staff within the practice with additional input from the GP's as required.

Opportunistic health checks were being carried out with patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks including blood tests as appropriate, and reminders to have medication reviews.

The practice was proactive in seeking feedback and the patient participation group at the practice included working age members.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer

appointments for people with a learning disability and their carers for reviews. Home visits by GPs were being carried out jointly with the community nursing team to reduce stress and improve communication. The practice liaised closely with with the learning disability nurse specialist to ensure information was communicated in a person centred way, for example in easy read or picture formats.

Health education, screening and immunisation programmes were offered as appropriate. This included alcohol and drug screening. Patients with alcohol addictions were referred to an alcohol service for support and treatment and to the local drug addiction service. Onsite counselling services provided by the local mental health partnership trust were available for patients and this included a self referral service.

The practice worked closely with the community matron to arrange visits to vulnerable patients to assess and arrange any equipment or other assistance needed by the patient and their carers.

Systems were in place to help safeguard vulnerable adults. The practice welcomed all patients to the practice and had systems in place to temporarily register and communicate with people of no fixed abode.

Carer checks were carried out and the practice hosted a carer support worker clinic every month to support patients.

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).

Flexible services and appointments were available. Patients were able to book an appointment via an online appointment booking system, over the telephone or in person. Longer appointments were offered at quieter times of the day, avoiding times when people might find this stressful.

Staff were skilled in recognising and responding to patients experiencing mental health crisis, providing support to access emergency care and treatment. The practice worked collaboratively with community mental health teams and the consultant psychiatrists from the mental health partnership trust.

The practice had a list of patients with known mental health needs and worked to engage them in healthy living programmes. Each appointment with a patient was seen as an opportunity to screen

patients and signpost them to additional services. In house mental health medication reviews were conducted to ensure patients received appropriate doses. For example, patient taking lithium had regular blood tests to ensure safe prescribing.

Advice and support was sought as appropriate from the psychiatric team with referrals made for psychiatry review or entry into counselling. Patients may be encouraged to refer themselves to the counselling service. The practice had a system in place to follow up patients diagnosed with depression if they did not attend appointments.

Early identification of patients with suspected dementia were being screened and referred to the memory clinic for diagnostic tests. Advanced care planning was promoted, with 75% patients having been reviewed. The practice was working closely with the CCG and community to develop a health and social hub in Crediton to provide services to support patients experiencing poor mental health. Services are likely to include counselling and a memory cafe.

Systems were in place to help safeguard vulnerable adults.

Summary of findings

What people who use the service say

The practice sought feedback from patients in several ways. Three surveys, including the 2014 national GP survey showed that results for Chiddenbrook surgery were better in all areas compared to the clinical commissioning group (CCG) and national average. The practice had a complaints and suggestion box in the surgery, with comments reviewed every month at the practice meeting. Social networking sites such as facebook and the practice website were also used to collect feedback from patients. It was too early to assess the impact of these initiatives as to whether they were useful means to obtain patient views.

During the inspection, we spoke with three patients and three representatives of the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the

inspection. Our comment box was displayed and comment cards had been made available for patients to share their experiences with us. We collected 25 comment cards, which contained detailed positive feedback about the practice.

The overarching theme from patients in their responses was that they were grateful for the caring attitude of the staff who took time to listen. Staff were described by patients as being kind, compassionate and responsive when they saw them. Patients were confident about the advice given and medical knowledge of their GPs. Access to appointments and the length of time given was described as a high point by patients who told us they never felt rushed. Patients were positive about the continuity of care they received from the team. Some patients were also carers and told us they received excellent support, which helped them care for their loved ones.

These findings were reflected during our conversations with patients and discussion with the PPG members. All of the patients gave positive feedback. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were excellent and thorough when it came to diagnosis and treatment.

Parents told us the staff treated their children with respect. We were told the staff were good at communicating with children and young people, which in turn helped reduce any anxieties they might have had about visiting the practice.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients felt listened to and told us they had no complaints. They showed us information about how to make complaints, which was clearly displayed and told us they were confident that if they did have any concerns they would be acted upon.

Patients were satisfied with the facilities at the practice. The building was highlighted as being accessible for people using mobility aids, safe, clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the website was good.

Areas for improvement

Action the service MUST take to improve

Ensure that patients are protected by gathering and reviewing the information in relation to people working at the practice. This concerns the recruitment of staff and the personnel information required including proof of identity, qualifications, employment history and relevant criminal record checks are carried out, if necessary to the role, and the relevant information retained as required by the legislation.

Summary of findings

Action the service SHOULD take to improve

Have a consistent information governance system across all policies and procedures to ensure these are up to date and consistent with current legislation

Outstanding practice

- The practice took an early intervention approach and had set up an educational programme for patients at risk of developing diabetes. This was run over a course of sessions in the evenings and helped patients change their lifestyles through the weight management or smoking cessation programmes where further advice and support was provided. Data showed 97% of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%.
- Vulnerable patients were referred to an innovative and successful community service, which engaged isolated adults in a rural area through stimulating, creative and social activities. A GP at the practice was one of the founding members and an active partner in this community service. The practice was also actively involved in the development of a community hub service in Crediton in partnership with other agencies.

Drs Shorney, Twomey, Murphy, Braddick and Griffiths

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 and another specialist who was a practice manager.

Background to Drs Shorney, Twomey, Murphy, Braddick and Griffiths

The GP partnership run the practice from Chiddenbrook Surgery and provide primary medical services to people living in the town of Crediton and the surrounding villages.

At the time of our inspection there were 7334 patients registered at the practice. The practice is contracted to provide primary and general medical services. There are six GP partners, four male and two female, who held managerial and financial responsibility for running the business. The GPs were supported by three registered nurses, two health care assistants, a phlebotomist, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

Chiddenbrook Surgery is open from 8.30 am - 6pm Monday to Friday. Extended opening hours are held four times a week starting from 7.30 am on Mondays and Fridays. Late evening pre booked appointments are available every evening on Tuesdays to Thursdays between 6.30 - 7.30pm During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Northern, Eastern and Western Devon clinical commissioning group.

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 visiting the practice, we reviewed a range of information we held about the service and asked other

Detailed findings

organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 25 November 2014.

During our visit we spoke with six GPs, the practice manager, three registered nurses, a healthcare assistant and phlebotomist, administrative and reception staff. We also spoke with three patients who used the practice and met three representatives of the patient participation group. We observed how patients were being cared for and reviewed 25 comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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

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

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

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

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 report incidents and near misses.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we reviewed these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. Learning from significant was shared with relevant staff and changes made. All of the staff knew how to raise an issue for consideration at the meetings and were encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us 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 the practice convened a meeting with hospital specialists, including the microbiologist and infection control nurse specialist to review discharge information, which did not highlight that a patient had contracted an infection whilst in hospital. Prescribing risks for using broad spectrum antibiotics were known. However, the practice chose to raise awareness of this again. The practice also highlighted that staff should try to establish whether any patient being discharge from hospital could be at risk of having a hospital acquired infection.

National patient safety alerts were disseminated by email to practice staff. For example, a recent alert about medicine used to allay symptoms of nausea and vomiting for patients had been circulated. The prescribing lead GP explained that a list of patients prescribed this medicine was produced. The named GPs for each patient had been asked to review the medicines with them and make changes where necessary.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff had received relevant role specific training on safeguarding. GPs, nurses and administrative staff were able to describe recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and linked with other siblings and family members registered at the practice. GPs were using the required codes appropriately on the 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 GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. For example, staff told us about how they had dealt with concerns recently about a child whose behaviour had changed and had observed inappropriate interactions between the child and parent. The concerns were discussed and an alert made to the multi agency safeguarding hub (MASH) for further investigation.

Requires improvement

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Medicines were stored securely in the treatment rooms and medicine refrigerators and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

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.

Records of practice meetings demonstrated that actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were average when compared with local and national data.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines was seen. Two of the nursing staff were qualified as independent prescribers and they had received regular supervision and support in their role. In discussion, they described how they updated their skills for the particular areas of expertise they covered. For example, one of these nurses saw patients with minor injuries and treated them.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Two anonymised patient records were seen which confirmed that the procedure was being followed.

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 a small stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place 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 and the keys held securely. There were individual registers, which linked with a main register which provided an audit trail of when controlled medicines had been used, for which patient and the total remaining. There were arrangements in place for the destruction of controlled drugs. However, we found one vial of out of date medicine which had not be taken out of use. This was immediately rectified and the practice put in place a further system to carry out monthly checks of GP bags to reduce the risk of this happening again.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

The premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. In 25 comment cards, patients remarked that they were satisfied with the standard of cleanliness at the practice. All eight patients we spoke were also satisfied with the cleanliness and infection control at the practice.

The practice had a lead nurse 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. New staff had received induction training about infection control specific to their role. The lead nurse had carried out audits for each of the last three years and

improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and the actions implemented.

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. Staff were able to describe how they would use these to comply with the practice's infection control policy. For example, we saw there was a designated box for patients to put samples in and a protocol followed each time it was emptied. Healthcare assistants and nursing staff handled the samples, carried out checks and then safely disposed of the contents. The practice had a needle stick injury policy in place 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.

The infection control policy did not make reference to other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessment. However, the practice was following suitable procedures for the management, testing and investigation of legionella. This is a bacterium that can grow in contaminated water and can be potentially fatal. However, there was no written procedure in place. Records confirmed the practice was carrying out regular checks in line with national guidance to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records demonstrated this was happening. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and certain types of equipment were calibrated for accuracy for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice consulted an outside agency for support and guidance about Human Resources and had a generic recruitment policy in place supplied by the agency. We found the recruitment procedures were not being followed consistently and therefore did not meet legal requirements. For example, two out of three files contained a criminal record check using the Disclosure and Barring Service (DBS). One of the DBS checks had been carried out by another employer and no new check had been completed by the practice. The third file had information, showing that the individual had been employed for an administrative role and had been given chaperone training. The practice manager verified that some of the administrative staff could carry out chaperone duties. We saw a certificates showing that this member of staff had received training about the role of a chaperone. However, a DBS had not been obtained for this person and there was no risk assessment on file to support the decision not to obtain one. We spoke with the practice manager about the processes followed for checking documentary evidence of current DBS, insurance and entry on the performers list for locum GPs. We asked to see evidence to demonstrate that checks for a locum GP who was used regularly and currently working at the practice had been carried out but this could not be produced. All three of the recruitment files seen had evidence that verbal references were undertaken and recorded, as well as verification of written references from past employers which were supplied by the applicant and had not been requested by the practice.

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. The turnover was low.

Requires improvement

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly 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. Records seen showed that appropriate checks were carried out, for example fire safety equipment had been tested in the last 12 months. However, records and interviews with staff confirmed that there were gaps in health and safety training. For example, three staff files had an induction date but no written record of the content or assessment of competence completed. The training matrix sent before the inspection was highlighted to show where staff were due training or an update. Minutes for a staff meeting in October 2014, had identified these training gaps. The practice had set a goal for staff to complete one area per month starting in November 2014. Incentives such as a financial bonus were being offered staff who had completed the module in the designated month.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team. The practice was able to produce electronic charts showing the range of temperatures and audits undertaken. For example, an audit looked at how effective procedures had been over a six month period. The practice found that when staff had been on holiday daily readings had not been checked. As a result of this learning, the practice had made changes and put a buddy system in place so that this did not happen again. Staff reported that a further audit had shown staff were adhering to the policy and no gaps in refrigerator temperatures had been reported.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly and this was supported by patients comments. For example, a parent with a baby explained how reassuring and attentive the team were in response to their concerns about their baby's ill health. The patient told us their GP was waiting for them and they were seen immediately, given emergency treatment and monitored until an ambulance arrived to transport them to hospital.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records demonstrated that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All of the 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 of their location. These included those for the treatment of cardiac arrest, anaphylaxis, suspected meningitis, hypoglycaemia, severe asthma, overdose, nausea and vomitting and epileptic fit. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. 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 heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The last fire drill had taken place 18 months previously in 2013. None of the staff listed on the training matrix had completed fire training in the previous 12 months. However, the practice manager confirmed that this had been booked for January 2015.

Risks associated with service and staffing changes both planned and unplanned were required to be included on the practice risk log. We saw an example of how the practice had managed a period of long term sickness of

some staff in the team. The practice manager verified that locum staff known to the practice had been for some sessions, but the team had provided the vast majority of cover required over that period.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Weekly meetings were held every Monday at which the latest guidelines and research was discussed. For example, one of the GPs had presented a summary of the latest guidance about how to manage patients with high lipid levels. Minutes were held of these meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. Our discussions with the GPs and nurses demonstrated that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as end of life care, diabetes, heart disease and asthma. GPs told us that the practice had a strong historical tradition in leading innovation in areas such as patient record systems and the hospice movement. Practice nurses had additional qualifications which allowed the practice to focus on specific conditions. Data for the local CCG showed that the practice performance for monitoring patients with long term conditions was comparable with other practices.

Data from the local CCG of the practice's performance for antibiotic prescribing demonstrated that this was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients every three weeks and had on site meetings with other health and social care professionals supporting them.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected liver disease. We looked at an audit which reviewed the context and appropriateness of the referrals made. We saw this lead to increased referral rates. Patients underwent further investigations that could not have been carried out in primary care settings and resulted in them receiving more timely treatment. Data seen also showed that patients with suspected cancers were referred and seen within two weeks.

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

Management, monitoring and improving outcomes for people

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

The practice showed us seven clinical audits that had been undertaken in the last three years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. For example, the practice was midway through the audit cycle reviewing patients with dementia who were prescribed antipsychotic medicines. The first audit showed that GPs were working within guidelines regarding their prescribing of antipsychotic medicines. The practice had implemented a quarterly search of patients and was reminding GPs to carry out reviews of patients on this medication. A second audit was scheduled to take place.

A GP partner completed a full cycle of audit to review prescribing practice as part of their revalidation. This took into account recommendations made by the joint GP information technology committee. The first cycle identified areas for improvement around recording, for

Good

Are services effective?

(for example, treatment is effective)

example number of items per page to reduce the risk of forgery, dose in figures rather than words and clearer instructions for patients. In between the first and second cycles a new electronic patient record system was installed. A second audit of prescribing practice reviewed 248 acute and repeat prescriptions for all doctors and the nurse practitioner. The findings showed that all except one of the above errors in prescription have been ironed out. The main on-going problem for all involved in prescribing was identified as the failure to attach a clear indication and accompanying instruction for the prescribed medicine. This was shared with key staff at practice meetings.

Following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to reduce blood cholesterol levels the GPs discussed the information and a clinical audit was carried out. The aim of the audit was to ensure that all patients prescribed this medicine in combination with a particular hypertensive drug were not put at risk of serious drug interactions. Patients who were on the combined medication, were assessed and changes made to their prescriptions to reduce the risk of complications occurring.

There was a protocol for repeat prescribing which was in line with national guidance. Repeat prescription requests were reviewed and signed off by a GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had implemented the gold standards framework for end of life care. One of the GPs specialised in palliative care and the practice worked closely with the local hospice so that patient were able to die in a place of their choice, which was often at home. A palliative care register was held and reviewed regularly. This included three weekly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term medical conditions were offered yearly health reviews The practice had systems in place to monitor and improve outcomes for patients. Each target area was risk rated and reviewed each week. This provided the staff with a clear picture of where they needed to prioritise reviews of patients with long term conditions. For example, the clinical team were focussing on reviewing patients with asthma and chronic pulmonary disease as this had been rated as high risk.

An annual flu vaccination programme was underway when we inspected. This included older patients, those with a long term medical condition, pregnant women, babies and young children. For patients within the relevant age range a vaccination against shingles was also available. The practice held clinics on a Saturday as well as when patients attended for other appointments so they did not have to make unnecessary trips to the practice. Patients were contacted via text, phone or email. Data showed that 95% diabetic patients had been vaccinated against flu.

Data showed 97% of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%.

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 78% which was comparable with the national average of 82%.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as child care, learning disabilities and complex mental health care. Each GP also had specific interests in developing their skills and disseminating this to the team covering long term conditions such as diabetes, chronic respiratory disease asthma and female sexual health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the GMC can the GP continue to practice and remain on the performers list with the NHS England.

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals with the practice manager and a GP which identified learning needs. Mandatory training was provided on-line. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example keeping up to date with wound dressings.

The nursing staff received their clinical appraisal from a GP at the practice. All of the nurses told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. The nurses had received extensive training for their roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines and undertaking cervical smears. One nurse had advanced qualifications and was able to prescribe medicines and treat minor injuries.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. There were policies in place outlining the responsibilities of all relevant staff in passing on, reading and actioned any issues arising from communications with other care providers on the day they were received. The partner GPs were responsible for seeing these documents and results and for the action required. Staff understood their roles and felt the system in place worked well. Results and discharge summaries were followed up appropriately and in a timely way.

The practice worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children. Every three weeks there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team. The practice had a list of vulnerable adults and worked closely with community professionals. For example, the practice worked closely with learning disability nurse specialist to build a trusting rapport so that the health and wellbeing of patients with complex learning disabilities was monitored. Data showed that the practice performed better than expected for completing annual health checks for patients with learning disabilities.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Special notes were shared with the 111 and Out of Hours services for patients with complex needs who needed continuity of care and treatment overnight.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, 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.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in promoting patient rights. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. For example, the team worked closely with the learning disability nurse specialist to ensure information was set out in a format suitable for a patient. The practice used picture and easy read information when explaining procedures such as blood taking.

All 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. Close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided. The practice provided information about contraception for young people. GPs told us that they took a team approach by discussing situations with each other at a lunchtime meeting each day. They told us this then avoided mixed messages being given to young people about contraception and other health matters. The practice

Good

Are services effective?

(for example, treatment is effective)

offered advice and carried out confidential chlamydia screening. Parents with children attending the practice confirmed that they were always present during consultations. They told us that all of the staff spoke to their child at their level and helped to reduce any anxiety they might be feeling.

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. Nursing staff also recorded patient consent for procedures such as wound dressing, blood taking or cervical screening.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. The practice website contained information and advice about other services which could support them. The practice offered new patients a health check with a healthcare assistant or with a GP if a patient was on specific medicines when they joined the practice.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be taken at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by patients we spoke with who were in this position as it avoided them having to travel to the opthalmology clinic based at the main hospital approximately 20 miles away. Outside agencies used the consulting rooms at the practice. For example, a breast feeding advisor used a private room to support and teach new mother's to breast feed their babies.

There was information on how patients could access external services for sexual health advice. Younger patients could request confidential testing for chlamydia infection. An information leaflet was advertised on the practice website.

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Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

GPs told us that they supported patients living in several care homes in the area. GPs said they aimed to promote patient dignity and respect in the way they approached requests for a home visit. They told us they did so by overriding the normal triage system in place at the practice and assessed patients at their home.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 25 completed cards and all were positive about the care and treatment experienced. Patients said they felt the practice offered very good services and staff were caring, helpful and professional. They said staff treated them with dignity and respect. Patients were complimentary about reception staff and told us that every effort was made to give them a same day appointment even for routine issues.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations and we did not overhear any conversations taking place in these rooms.

We saw staff were discreet when discussing patients' treatments in order that confidential information was kept private. There were additional areas available should patients want to speak confidentially away from the reception area. We sat in the waiting room and observed patient experiences as they arrived for appointments. Reception staff were pleasant and treated patients with respect.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were able to explain how they diffused situations to avoid further escalation of a patients frustration or anger.

Care planning and involvement in decisions about care and treatment

Data showed that the practice was performing better with regard to maintaining a palliative care register for patients. GPs told us that treatment escalation plans were routinely discussed with patients on the register and their wishes about end of life care needs recorded. Minutes of the monthly multidisciplinary meeting demonstrated these were being followed for patients.

Patient survey information demonstrated that the practice achieved a better than expected level of patient involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 96% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results.

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being good at listening to their needs and acting on their wishes. Patients said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 25 comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. Notices in the reception areas and information on the practice website explained the translation services available in a number of languages.

Patient/carer support to cope emotionally with care and treatment

GP patient survey data showed 95% patients described the overall experience of their GP surgery as fairly

good or very good. The 25 comment cards we received were consistent in describing positive experiences about the care and treatment they had received. Patients highlighted that staff responded compassionately when they needed help and described as going beyond what was expected of them. The practice ran a monthly carers clinic in conjunction a community support worker, to provide practical and emotional support for patients who were carers.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Written information was also displayed in the waiting room explaining the various avenues of support available to carers.

Good

Are services caring?

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 and location to meet the family's needs and/or by giving them advice on how to find a support service. The patients we spoke with gave us examples of the support received from practice staff when they had experienced difficult and challenging times in their lives. For example a patient who was also a carer for their spouse who was diagnosed with dementia described the emotional support they had received after a telephone consultation with their GP. They told us they were pleasantly surprised when within an hour of the call the GP arrived at their home to help support them.

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 had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice held registers for each group including one for vulnerable patients so that the support, care and treatment was patient centred. GPs told us that the practice evaluated new approaches to responding to patient needs. For example, a telephone recall system for patients had resulted in reduced response. The practice had taken the decision to revert to sending out letters to patients instead.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Operational meetings were held at the practice every month. We saw minutes for the October 2014 meeting, which showed that the practice had provided a report to NHS England about unplanned admissions of patients to hospital. This confirmed that patients had care plans in place. We saw other minutes showing that GPs worked in collaboration with other health and social care professionals to support these patients at home.

Twenty five patients commented that the prescription system was good. Some patients used the on line request service, whilst others called in to collect their prescription and take it to a local chemist. The practice had arrangements in place for more vulnerable patients so that prescriptions were sent automatically to the chemist of choice. The chemist then delivered the medicines direct to the patient. All patients said the process was efficient and took a couple of days.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). An action plan was published on the website, showing the response and current status of actions taken. For example, three representatives of the PPG told us that they were involved in a current project to reduce costs and risks of miss prescribing medicines for patients. They told us the CCG pharmacist advisor was working with the practice and PPG members to agree a system, which would see patients updating medicines information and reviews of prescribing being done more frequently.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed or were completing the equality and diversity training. All of the staff told us that equality and diversity was regularly discussed at staff appraisals and team events.

The practice was situated on two floor with most services for patients at ground floor level. The practice was accessible for patients in wheelchairs with ramp access to the side of the premises. There were automatic doors into the premises which could be activated by pressing a button. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had an audio loop in the waiting room for those with hearing aids. We highlighted in the feedback session that staff had explained that the equipment was not permanently switched on. Information displayed in the waiting area asked patients to tell the receptionists on arrival therefore this placed the responsibility with patients to explain their disability and was not a proactive approach to promoting equality.

The practice had systems in place to support patients whose circumstances may make them vulnerable. For example, the practice had a register of patients who may be living in vulnerable circumstances, with specific information in individual records about potential risks and support that was needed. GPs told us there were no barriers for patients with "no fixed abode" and workarounds were in place to record contact information. Staff told us they tried to fit patients in for appointments if they presented on the day, making appointments accessible. Patients in 25 comment cards confirmed that this was also their experience of the appointment system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice had extended opening times each day. Two days per week the practice was open from 7.30am onwards and on three days a week open late between 6.30 pm and 7.30pm.

Flexible arrangements were in place for working age patients, which extended the opportunities for health screening to take place at one appointment. Repeat prescribing requests could be made by patients on line and in some circumstances for up to six months as appropriate. For example, the way patients were invited to attend health screen checks had been reviewed, making it a more personalised and successful service. Extended evening appointments for 20 minutes were offered and had resulted in an increased uptake of patients aged 40-74 years old being screened. Potential health risks for some patients had been identified and early interventions such as information about leading a healthy lifestyle or signposting to other services had taken place.

Feedback cards completed by 25 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Three patients we spoke with told us the appointment system was accessible, by telephone, online or bookable in person. They confirmed urgent appointments were available on the same day. We saw reception staff answered the telephone to patients in a friendly way and were accommodating in getting them appointments to see the GPs or nurses.

The practice used a triage system and offered telephone appointments for patients. Patients told us their GP usually telephoned them back after morning surgery, which they felt was a good alternative to attending in person for minor issues. There was a skill mix of staff, including nurses with advanced qualifications that enabled them to run additional nurse led clinics and treat minor injuries.

Longer appointments were also available for patients who needed them and those with long-term conditions. For example, patients with learning disabilities and/or mental health needs were offered appointments at quieter times of the day and for longer periods. Onsite counselling services were available on site provided by the local mental health partnership trust. Information was displayed in waiting areas for patients and highlighted they could self refer to these counselling services if they wished to.

The practice was in semi rural location, with limited transport links to the main hospital situated some 10 miles away. Through fundraising various specialist equipment had been purchased to promote patient access to services and speed up results and treatment. For example, the practice had two advanced pieces of equipment to provide immediate blood results for patients taking anti clotting medicines. This allowed immediate decisions to be taken with the patient about any changes needed to the dose of these medicines.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice. We looked at 22 complaints received from patients, all of which had received a prompt acknowledgement and outcome in writing.

The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. Complaints had been analysed and identified themes around prescriptions, bedside manner and clinical issues. For example, a complaint about handling chest pain symptoms of a patient was looked at. Records showed that the incident had also been discussed through the significant event process and changes made to practice as a result.

None of the three patients we spoke with, or 25 patients who gave written comments had ever made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager.

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 clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. We spoke with 15 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Patients comments in person and in the 25 comment cards received confirmed this was their experience of the practice.

Staff morale was said to be improving at the practice after experiencing additional pressures whilst some key staff were on long term sickness. Staff said they felt valued and were encouraged to do the best for patients. The practice team was managed in an open and transparent way at the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. Some of these but not all were available to staff on the desktop on any computer within the practice. The practice manager verified that they used the NHS information governance tool kit but had not added evidence to it due to time constraints. The tool kit was developed by the Department of Health to encourage services to self assess so that they could be assured that practices, for example, have clear management structures and responsibilities set out, manage and store information in a secure, confidential way that meets and data protection. We looked at some of these policies and procedures, which included those covering safeguarding, infection control, recruitment. Two of the policies had review dates and information about governance arrangements. The practice manager verified that the recruitment procedure used was one provided by an external consulted specialising in HR practice. There were minor gaps in the infection control policy.which did not make reference to other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessment.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 15 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 and in some instances better than expected with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, infection control audits had been carried out annually. We discussed the findings from the audit carried out in October 2014. This highlighted that the practice did not have up to date information about staff training records to provide assurances that all the staff had received infection control training. We were shown four examples of personal development plans, which had been put in place since this audit. However, the information had not been transferred to the practice training matrix to provide oversight of the skill base of the whole team of staff.

The practice had arrangements for identifying, recording and managing risks. Risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, monthly operational management meetings were held to review business, identify and mitigate potential risks. We looked at minutes of the operational management meeting held in October 2014. One issue highlighted as a risk which had been addressed related to the cold chain procedure for vaccines. Actions to reduce the risk were recorded and included a review of the procedures, repair of a fridge and assurance that vaccines were still viable after an incident had occurred. These procedures were being followed during the inspection providing the practice with assurance that the vaccines were safe to use with patients.

Are services well-led?

Good

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

Leadership, openness and transparency

Meetings were held every month and minutes kept and circulated via email to the team. 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. Team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, induction policy and management of health and safety which were in place to support staff. Staff knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The importance of patient feedback was recognised and there was an active patient participation group (PPG), which worked in collaboration with a charity set up by the practice for fundraising. Three members of the PPG said that the GP partners and practice manager listened and acted on suggestions made. They explained that the GP partners always explained any potential barriers for change, which usually related to matters outside of their control such as NHS budget constraints. Plans to develop the services were openly discussed with the PPG such as being involved in development of a community hub for people living in Credition. The practice was proactive in engaging the help of members during the recent flu vaccination campaign. The PPG said they had a key role in fund raising and had hosted an open evening to do this. Fund raising was focussed on improving equipment and the physical environment, for example high quality wooden toys had been purchased and a child play area set up off the main waiting area. A blood pressure (BP) machine had been purchased for patient use in the waiting area, with information for patients highlighting the normal range for adults. This included advice to tell their GP if their BP was outside of this normal range.

Management lead through learning and improvement

A random selection of five staff files showed that annual appraisal were carried out. Training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff files contained evidence of professional training and reflection on specific issues. Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by a line manager with the appropriate skills, qualifications and experience to undertake this role.

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, one audit showed that a GP had carried out a review of their prescribing practice to determine if this was in line with patient needs and national guidance. This showed the GP was responsive to patient needs in their prescribing practice and potential risks were always explored with the patient. Another example seen was the revalidation of nurses in cervical screening every 3 years. Nurse held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients, were reviewed by the lead nurse. Mentoring and support was provided where needed to improve skills and accuracy with such 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not have adequate recruitment arrangements in place in accordance with Schedule 3 of the Health and Social Care Act 2008. The required employment checks were not in place for all staff. Key documentation was missing from staff files to demonstrate their fitness to work at the practice.**