

Culverhay Surgery

Quality Report

The Culverhay Surgery
Wotton-Under-Edge
Gloucestershire
GL12 7LS
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Date of inspection visit: 9 December 2014
Date of publication: 09/04/2015

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

The Culverhay Surgery in Wotton-Under-Edge was inspected on the 9 December 2014. This was a comprehensive inspection.

The Culverhay Surgery in Wotton-Under-Edge Gloucestershire, GL12 7LS provides primary medical services to people living in the town of Wotton-Under-Edge and the surrounding villages. The practice also has two branch surgeries. One in Wickwar, held in the Community Centre, Avon Crescent on Monday afternoons from 12 noon, and a second in Hawkesbury Upton at the Bethesda Chapel, Park Street on Wednesdays from 12:30pm. We did not visit these branches as part of our inspection.

At the time of our inspection there were approximately 6,300 patients registered at the Culverhay Surgery. This is a dispensing practice and provides a dispensing service to approximately 40% of the practice population. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy.

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

The practice has opted out of providing out of hours services to their own patients and refers them at evenings and weekends, when the practice is closed, an Out of Hours service delivered by another provider.

We rated this practice as Good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from incidents were taken advantage of.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group.
- Patients had a variety of ways to make appointments and found the practice to be flexible in meeting their needs. We were told patients could always get an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients told us the practice was clean and safe.

- The practice had a clear vision which had quality and safety as its first priority and high standards were promoted and owned by all practice staff with evidence of team working across all roles.

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

Action the provider SHOULD take to improve:

- All clinical staff should receive training in the Mental Capacity Act (2005). The MCA is a legal framework which supports patients who needs assistance to make important decisions.

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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Medicines were stored, managed and dispensed in line with national guidance. There were safeguards in place to identify children and adults in vulnerable circumstances. There was enough staff to keep people safe. Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard.

Good



Are services effective?

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

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice reviewed and understood the needs of their local

Good



Summary of findings

population. The practice identified and took action to make improvements. Patients reported that they could access the practice when they needed. Patients reported that their care was good. The practice was well equipped to treat patients and meet their needs.

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

Are services well-led?

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

The practice had an active patient participation group (PPG) which was involved in the core decision making processes of the practice.

Good



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

The practice is rated as good for providing care to older people. All patients over 75 years had a named GP. Health checks and promotion were offered to this group of patients. There were safeguards in place to identify adults in vulnerable circumstances. The practice worked well with external professionals in delivering care to older patients, including end of life care. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people on set days as well as during routine appointments. Staff recognised that some patients required additional help when being referred to other agencies and assisted them with this.

Good



People with long term conditions

The practice is rated as good for providing care to people with long term conditions. The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes and asthma. Longer appointments were available for patients if required, such as those with long term conditions. The practice had a carers' register and all carers were offered an appointment for a carers' check with nursing staff. Patients were screened for depression if appropriate. All patients suffering with asthma or chronic obstructive pulmonary disease had a care plan.

Good



Families, children and young people

The practice is rated as good for families, children and young people. Staff worked well with the midwife to provide prenatal and postnatal care. Postnatal health checks were provided by a GP. The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening. Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. The practice has an arrangement with another local practice for young people to use its services. The GPs training in safeguarding children from abuse was at the required level.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for providing care to working age people. The practice provided appointments on the same day. Emergency appointments were available. The practice operated extended opening hours one evening a week. Smoking cessation appointments were available. The practice website invited all patients aged between 40 years to 75 years to arrange to have a health check with a nurse if they wanted. A cervical screening service was available.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for people whose circumstances may make them vulnerable. The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at team meetings. Referral to a counselling service was available. The practice did not provide primary care services for patients who are homeless as none are known, however, staff said they would not turn away a patient if they needed primary care and could not access it. Patients with interpretation requirements were known to the practice and staff knew how to access these services. Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed and send letters for appointments.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for people experiencing poor mental health, including people with dementia. The practice is aware of their aging population group. Staff were aware of the safeguarding principles and GPs and nurses had access to safeguarding policies. The nurses had not received training in the Mental Capacity Act (MCA) 2005 but were aware of the principles and used them when gaining consent. There was signposting and information available to patients. The practice referred patients who needed mental health services and community psychiatric nurses visited the practice. Some support services were provided at the practice, such as Talking Therapies. Patients suffering poor mental health were offered annual health checks as recommended by national guidelines. Longer appointment times were available and volunteers offering transport was used for patients to access the practice.

Summary of findings

What people who use the service say

We looked at patient experience feedback from the national GP survey from 2014/2015. The patient's survey showed 90% of patients were able to see or speak to their preferred GP, which was higher than the CCG average of 68%. 81% said that they had a 15 minute wait to see the GP. This again was higher than the CCG average of 84%. The patient survey was conducted by the PPG in January 2014. Every patient visiting the practice were asked to complete a questionnaire. 171 were completed and they showed that 83% of the patients found the receptionists helpful and 79% were satisfied with the practice overall.

We spoke with four patients during the inspection and collected 27 completed comment cards which had been left in the reception area for patients to fill in before we

visited. All of the feedback was positive. Patients told us the staff were friendly, they were treated with respect, their care was very good, and they were always able to get an appointment. The comment cards also told us how they felt listened to by the staff and how supportive staff were.

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

Patients found it easy to get repeat prescriptions from the practice.

Areas for improvement

Action the service SHOULD take to improve

Action the provider SHOULD take to improve:

Ensure all staff receives training in the Mental Capacity Act 2005.

Culverhay Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Culverhay Surgery

The Culverhay Surgery in Wotton-Under-Edge Gloucestershire, GL12 7LS provides primary medical services to people living in the town of Wotton-Under-Edge and the surrounding villages. The practice also has two branch surgeries. One in Wickwar, held in the Community Centre, Avon Crescent on Monday afternoons from 12 noon, and a second in Hawkesbury Upton at the Bethesda Chapel, Park Street on Wednesdays from 12:30pm. We did not visit these branches as part of our inspection. The practice is a training practice for qualified doctors undertaking training to become a GP.

At the time of our inspection there were approximately 6,300 patients registered at the Culverhay Surgery. There were three GP partners, three male and one female, who held managerial and financial responsibility for running the business. In addition there was one male associate GP and one female salaried GP who worked three sessions a week. The GPs were supported by three registered nurses, one being a nurse prescriber, a healthcare assistant, a practice manager, and additional administrative and reception staff. Patients using the practice also had access to community staff including district nurses, health visitors, and midwives

Culverhay Surgery is open from 8 am until 6pm Monday, Tuesday, Thursday and Friday and 8:30am to 1:00pm on

Wednesday. Late evening pre booked appointments are available on Monday until 8pm for patients that find it difficult to visit the GP during the day. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

The practice also has a dispensary that is open Monday to Friday between 09:00am to 1:00pm and 3:00pm to 6:00pm with the exception of Wednesday when it is closed from 1:00pm onwards.

CQC intelligent monitoring placed the practice in band One. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

Detailed findings

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Healthwatch, and NHS England. We visited the Culverhay Surgery on 9 December 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff, and patients. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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)

Are services safe?

Our findings

Safe track record

Systems were in place for reporting and responding to incidents. All safety alerts were dealt with by the GPs, nurses and reception team. Patients told us they felt safe when attending the practice. The practice had chaperone policy in place. A chaperone is a third person of the patient's choice, who may accompany them during consultation, treatment or physical examination.

The practice manager told us that when they received MHRA alerts (medical alerts about medicines safety) they searched their patient records to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. The lead GP would also be informed and they shared medical alert information with other clinical staff in the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during 2014 and we were able to review these. Significant events were a standing item on the monthly practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example a patient had been given a second vaccine in error, this had prompted the practice to re visit how staff recorded treatments given. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three 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.

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.

Medicines management

The Culverhay surgery is a dispensing practice. We looked at the procedures for storage and safe dispensing of medicines. There were standard operating procedures (SOP) for dispensing in operation. The practice only stored limited stocks of regular items and new supplies could be ordered twice a day. We saw documentation that demonstrated the practice checked and balanced stock levels.

Opening times for the dispensary were clearly posted on the door with details of where patients could obtain medicines when they were closed. The dispensary could only dispense to patients living more than one mile away from the practice or local chemist. They arranged for patients medicines to be delivered to post offices in neighbouring villages for collection. Safe processes had been put in place.

Are services safe?

There was a clear audit trail for the authorisation and review of repeat prescriptions. Alerts were raised when the GP was required to review the medicines or if the patient requested medicines early. Any changes to the patient's medicines were flagged on the computer system. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

Controlled drugs were stored correctly with only relevant staff having access. We looked at the controlled drugs (CD) book and saw that correct procedures were in place for storage and administration and disposal.

All staff working in the dispensary had completed accredited training. The GP lead for medicines management audited the staff competencies annually and we saw records that showed the dispensing staff kept up to date with training.

Refrigerators were available for the storage of vaccines. A nurse checked and recorded the temperatures twice daily. They told us that any abnormal readings would be reported to the practice manager for action to be taken. This demonstrated the staff recognised the importance of storing vaccines at the correct temperature.

For security purposes prescription pads were not stored in the GP consulting rooms; GPs could print a named prescription from their computer system if a hand written item was required.

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 both sets of directions and evidence that the nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. All checks and calibrations were carried out in November 2014.

Are services safe?

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The staff worked part time hours and there was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual/sick leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

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 need for a lone working policy had been recognised and added to the agenda for the next meeting.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example, a healthcare assistant had recognised that a patient during a review was not their usual self which prompted a consultation with a GP.

The GPs were also able to provide examples of responding to emergencies of other patients including those with long term conditions and learning disabilities.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice also had a well stocked accessible first aid kit.

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, and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, 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. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Clinical Excellence (NICE) guidance and discussion around latest guidance was included in the staff meetings. Guidance from national travel vaccine websites had been followed by practice nurses.

The GPs and practice nurses told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and said they received support and advice from each other. Patients with specific conditions were reviewed to ensure they were receiving appropriate treatment and regular review. For example, blood pressure monitoring. A pod was available in a private area of the reception to allow for patients to test and record their own blood pressure.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, adult and child protection alerts management and medicines management.

The GPs told us clinical audits were often linked to medicines management information, for example, we saw an audit regarding the prescribing and monitoring of drugs used for pain relief, to ensure that the correct dosage and testing was being given to the patients and that patients were on the correct dosage. The GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The nurses told us of clinical audits they carried out, for example, auditing healing times for wounds and then changing techniques to increase healing times.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system

flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question, and where they continued to prescribe it, they had outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. The lead nurse received appraisal from the practice manager and a GP. The lead nurse and practice manager appraised the other nurses and healthcare assistants. The practice manager appraised all the administrative staff. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, a nurse told us that they had completed a diploma in Asthma.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospitals including discharge

Are services effective?

(for example, treatment is effective)

summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All the GPs who saw these documents and results were responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were not always attended by district nurses and palliative care nurses due to workload but we were told that patients requiring these disciplines would be discussed individually when the need arose. Decisions about care planning were documented in a shared care record. Staff felt this system worked well.

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 through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (SystemOne) 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

GPs and nurses we spoke with had an understanding of the Mental Capacity Act 2005 (MCA). They knew when it may be required to assess someone's capacity to make a decision and how a decision can be made in a patient's best

interests. However staff training had not undertaken training in this subject. GPs demonstrated a clear understanding of the Gillick competencies (guidance on gaining consent from patients under 16).

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

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Parental consent for child immunisations was also recorded.

Patients were able to complete advanced decision forms. Treatment escalation plans (TEP) were considered as part of care reviews, involving the patient's family when possible, as a means of avoiding hospital admission where possible.

Health promotion and prevention

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

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

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 100% had been offered an annual physical health check in the last 12 months.

The practice provided information on mental health support services on its website and external support

Are services effective?

(for example, treatment is effective)

services such as counselling. The practice used locally available services such as the volunteer car service used to assist patients to attend appointments and the Village Agents whose aim is to improve the quality of life and promote the independence of the older, isolated and vulnerable members of the community and include befriending, transport to local activities or to health appointments, prescription collection and carers support.

The practice offered patients who were eligible, a yearly flu vaccination. This included older patients, those with a long term medical condition, pregnant women, babies and young children. Patients with long term medical conditions were offered yearly health reviews. Patients with diabetes were offered six monthly reviews.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included a national survey performed in January 2013, and a survey undertaken by the practice's patient participation group (PPG) in January 2014. Evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the patient survey showed the practice was rated high for all outcomes including consideration, reassurance, and confidence in ability and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. Conversations could be overheard in the waiting room. The practice asked patients if they could overhear in the last patient satisfaction survey, 72% out of 170 responses said that they could but they didn't mind. 11% responded that they were not happy about it.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 91% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. Both these results were the same average compared to CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 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. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

A patient who had been with the practice for a long time told us their husband passed away earlier in the year following a long illness, and they felt well supported and cared for by the GPs and the nurses.

Notices in the patient waiting room, and patient website 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 available for carers to ensure they understood the various avenues of support available to them.

Are services caring?

Staff told us that if families had suffered 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' 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.

The practice welcomed feedback from patients and external bodies and used significant events, complaints and near misses to improve the services provided. To obtain additional feedback from patients a virtual group of patients had been formed and these patients were consulted about opening times, making routine and urgent appointments, telephone access, environment and the overall opinion of the practice.

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). The practice had received a good response from patients being able to book appointments on line and was exploring further ways to promote this service on their website and by texting patients.

Tackling inequity and promoting equality

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

The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team meetings.

The practice had level access for patients using wheelchairs and patients with pushchairs. The front door and corridors were wide and all consultation and treatment rooms were on the same floor level allowing easy access for wheelchair users. A separate play area with a selection of toys for distraction was available for younger children. We saw that the waiting area was large enough to accommodate

patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had the medical equipment it required to provide the services it offered. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place

The practice actively supported patients who had been on long-term sick leave to return to work by prescribing exercise at the local sports club.

Access to the service

Appointments were available from 9am to 11am and then from 4:30 until 6pm. Additional appointments were available at 11am for emergency appointments. Both the GP and nurse worked extended hours on Monday evenings to accommodate patients that had difficulty accessing the practice during the day.

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.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes by a GP for those patients who needed one.

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

Listening and learning from concerns and complaints

Are services responsive to people's needs? (for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was

displayed as well as information about advocacy services. Complaints forms were readily available on the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. 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.

Staff members told us they knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff told us this was a really good practice for team work, role development and training.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control; a GP partner was the lead for safeguarding and another GP partner the lead for child protection. Staff told us 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 under performing with national standards. Explanations were given to us for the cause of this. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to improve outcomes.

Leadership, openness and transparency

There was a clear leadership structure within the practice. Staff told us they were clear about their own roles and responsibilities. They all told us they thought the practice was well led and felt well supported and knew who to go to in the practice with any concerns. They also said there was

an open culture at the practice and they felt able to raise any concerns or discuss any issues with the senior staff. Team meetings were held regularly but if they had any issues these could be raised at any time.

The practice manager was responsible for human resource policies and procedures. We reviewed the recruitment policy and induction programme which were in place to support staff. We were shown the electronic information that was available to all staff, which included sections on employment and whistleblowing. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) which consisted of nine members. The age of members ranged from 30 – 79 years, with the majority of the group in the 65 – 74 age brackets. The PPG had worked with the practice staff to improve outcomes for the patients, for example, they held meetings at the practice to promote the on line booking system. They also assisted the nurse with booking the village hall to facilitate a dietician to give a talk to diabetic patients.

The PPG had carried out surveys and met regularly with the practice manager and a GP. They showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The practice and the PPG were actively recruiting for a 'virtual' group which would include those patients that could not or preferred not to commit to regular face-to-face meetings, but wished their views to be known.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that

Are services well-led?

Good 

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

regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and they also had regular lunch and review sessions.