

Hatherleigh Medical Centre

Quality Report

Hatherleigh Medical Centre
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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

Requires improvement



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?

Requires improvement



Summary of findings

Contents

Summary of this inspection

| | Page |
|---|------|
| Overall summary | 2 |
| The five questions we ask and what we found | 4 |
| The six population groups and what we found | 8 |
| What people who use the service say | 14 |
| Areas for improvement | 14 |
| Outstanding practice | 14 |

Detailed findings from this inspection

| | |
|--|----|
| Our inspection team | 15 |
| Background to Hatherleigh Medical Centre | 15 |
| Why we carried out this inspection | 15 |
| How we carried out this inspection | 15 |
| Detailed findings | 17 |
| Action we have told the provider to take | 30 |

Overall summary

Letter from the Chief Inspector of General Practice

Hatherleigh Medical Centre was inspected on Wednesday 15 April 2015. This was a comprehensive inspection.

Overall the practice is rated as requires improvement.

Specifically, we found the practice requires improvement for providing safe and well led services. It was good for providing a service which was caring, responsive and effective. It is rated as good for providing services to the six population groups.

Hatherleigh Medical Practice provides primary medical services to people living in Hatherleigh and the surrounding areas. This dispensing practice provides services to a primarily older population and is situated in a rural location.

At the time of our inspection there were 2,035 patients registered at the practice. Two GPs were in the process of registering their partnership. One GP held managerial and financial responsibility for running the business. There

were three salaried GPs. Four GPs were male and one was female. There was one practice nurse and one health care assistant and one phlebotomist at the practice. In addition there was a practice manager, and additional 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.

Our key findings were as follows:

- A recent change in ownership had caused a lack of clarity amongst staff about the leadership of the practice. Some staff felt unsupported.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed.
- Risks to patients were assessed and managed.

Summary of findings

- Data showed patient outcomes were average for the locality. Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested.
- The practice had a number of policies and procedures to govern activity. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- The practice was clean, had good facilities and was well equipped to treat patients.
- Feedback from patients we spoke with and from patient surveys about care and treatment was positive. However, two comments in the last two years on the NHS Choices website were negative.
- We observed a patient centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.
- Information received about the practice prior to and during the inspection demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

We found an area of outstanding practise:

In this rural farming area of mid Devon, the practice nurse reached out to a hard to reach group in the local

population, the local farmers. This was achieved by regularly organising and staffing a stand in the local weekly village market, offering blood pressure checks and health advice to patients. This service had been provided for over five years. Without this service, local farmers, who cannot easily take time off work sick or visit a GP practice, would find it very difficult to access these positive health promotions. At the most recent market day screenings, 26 patients had been seen. Of these patients, three had elevated blood sugars and three had elevated blood pressure. All patients were given healthy eating and lifestyle advice. Patients who recorded scores of elevated blood sugars or blood pressure were booked an appointment for future monitoring. Patients not registered at the practice who recorded elevated scores were advised to consult their own GP practice for future monitoring.

There was an area of practice where the provider must make improvements:

The practice was undergoing a transfer in ownership from one GP to another GP. As a result the staff expressed a lack of clarity in the leadership of the practice. The provider must ensure visible leadership at the practice on a regular basis in order to support good governance and to monitor risks at the practice.

There were also areas of practise where the provider should make improvements:

The most recent infection control audit had been undertaken in August 2013. The provider should ensure that a comprehensive infection control audit is carried out on an annual basis.

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 requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, recruitment procedures and checks were completed to ensure that staff were suitable and competent. The practice had a clear rationale not to perform a criminal records check via the disclosure barring service (DBS) for administration staff; this had not been recorded in a formal written risk assessment.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for. The practice had systems to help ensure patient safety and staff had appropriately responded to emergencies.

We found that the security arrangements for the keys to cupboards where medicines were stored needed to be reviewed. These arrangements were changed immediately on the day of our inspection. The fridge which contained vaccines was found to be unlocked in an unlocked treatment room. This was resolved on the day of the inspection.

Significant events and incidents were investigated both informally and formally. Staff were aware of the learning and actions taken. Monthly significant event meetings took place. We saw examples of significant events related to the dispensary. These had been appropriately recorded and learning points taken forward.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults from the risk of abuse. Staff had received safeguarding training within the last 12 months.

The practice was part of the dispensing services quality scheme (DSQS) with NHS England. This meant that the practice had

Requires improvement



Summary of findings

approved standard operating procedures in line with current practice. NHS England had assessed the practice's dispensing arrangements within the last 12 months and found them to be satisfactory.

The practice had not undertaken an infection control audit since August 2013.

Are services effective?

The practice is rated good for providing effective services. Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run.

The practice had a clinical audit system in place. We saw examples which included emergency admission audits, prescription audits and medication audits. Five clinical audits had been completed in the last 12 months and had led to service improvements.

Care and treatment was delivered in line with national current practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. A physiotherapist was based at the practice and had regular contact with nearby Okehampton Hospital. The practice had monthly meetings with the complex care team based at the practice in order to avoid unplanned admissions.

Information obtained both during and after the inspection showed staff employed at the practice had received appropriate training and appraisal. GP partner appraisals and revalidation 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. Data showed patients rated the practice higher than others for many aspects of care. Face to face feedback from patients and patient surveys about their care and treatment was consistently positive. However, patient feedback on the NHS Choices website showed that there had been two negative comments in the last two years.

We observed a patient centred culture and found evidence that staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Good



Summary of findings

Patients we spoke with during the inspection spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them about their physical, mental and emotional health and supported their health education. This aligned with the results of the national GP patient survey.

Patients told us they were included in the decision making process about their care and had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations.

Are services responsive to people's needs?

The practice was rated good for providing responsive services. Patients commented on how well the majority of staff communicated with them and praised their caring, professional attitudes. They told us that they felt listened to and their concerns and responded to appropriately.

There was information provided on how patients could complain. Complaints were managed according to the practice policy and within timescales. The practice had received three complaints in the last 12 months.

The practice recognised the importance of patient feedback and had encouraged the development of a patient participation group (PPG) to gain patients' views. The PPG had been in place for over two years and had 10 members. The PPG met up on a quarterly basis.

Practice staff had identified that not all patients found it easy to understand the care and treatment provided to them and made sure these patients were provided with relevant information in a way they understood. Staff used alternative formats to communicate with patients with a learning disability.

Patients said it was easy to get an appointment at the practice and were able to see a GP on the same day if it was urgent. The practice held walk in clinics on a daily basis.

Good



Are services well-led?

The practice is rated as requires improvement for providing well-led services.

The practice was undergoing a transfer in ownership. Not all staff were aware of the new leadership at the practice. Staff told us that at times they weren't sure who to approach with issues. As a result the staff expressed a lack of clarity in the leadership of the practice. The

Requires improvement



Summary of findings

provider must ensure visible leadership at the practice on a regular basis in order to support good governance and to monitor risks at the practice. This was acknowledged during the feedback session during our inspection.

The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. All staff had received inductions but not all staff had received regular performance reviews and attended staff meetings and events.

There was a programme of clinical audit in operation with clinical risk management tools used to reduce any risks to patients, staff and visitors.

Significant events, incidents and complaints were managed as they occurred and subsequently through a more formal process to identify, assess and manage risks to the health, welfare and safety of patients.

The practice sought feedback from patients and had an active patient participation group (PPG) which provided us with positive feedback about the practice.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for providing care to older people. The percentage of patients at the practice aged over 65 years was above the national average. Life expectancy in the local area was above the national average.

This small rural practice aimed to be in contact with the needs of this population group and the family unit. Staff told us that very often; this population group does not contact the practice directly to request support but relies on their family to do this. The practice offered annual health checks to patients in this population group.

Practice staff outlined the following tools to support patients in this population group. Complex care team meetings were held once a month, where the practice staff reviewed all of the relevant cases with the input of GPs, practice nurses, administrative staff, district nurses, physiotherapist, rehabilitation, social workers and any other relevant professionals. We saw written evidence of this in the minutes of the meetings.

The practice actively participated in avoiding unplanned admissions to hospital for this population group. Activities the practice undertook included having a named GP, review of the patient cases at weekly intervals and individual care plans which were frequently reviewed. This information was submitted to the CCG on a quarterly basis.

The practice conducted Quality Outcomes Framework (QOF) activity for conditions associated with this population group. QOF is a voluntary scheme which provides GP practices with incentives to meet national health targets. The practice checked their records frequently to ensure that patients with chronic obstructive pulmonary disease (COPD), diabetes or heart failure were contacted and offered health checks and appropriate treatment. In all of these areas the achievement in the practice was higher than 90 % of the maximum QOF points.

The practice held a monthly referrals review for older people. The practice was on target to achieve over 95 % of the reviews due of all patients in this population group. This was higher than the CCG average.

Requires improvement



Summary of findings

However, the practice had not carried out an infection control audit since August 2013 and this may put patients at higher risk of infection. In addition, staff told us that at times they weren't sure who to approach with issues. This called into question the leadership at the practice.

People with long term conditions

The practice is rated as requires improvement for providing care to people with long term conditions.

The practice provided patients in this population group a regular point of contact for the management of their long-term conditions. The practice offered chronic disease management through regular appointments with the practice nurse. The practice had developed the role of the practice nurse for the follow up of long-term conditions in order to ensure that they had the skills and qualifications to deliver this service to patients.

The practice had monthly or more frequent if necessary contact with the local complex care teams. This helped patients with long-term conditions with their holistic needs. The practice used high risk predictive scores to ensure prompt treatment and staff discussed the latest hospital admissions, discharges and deaths in order to support patients.

The practice undertook activity for the admission avoidance enhanced service, with the aim of avoiding unplanned hospital admissions for this population group.

The practice used QOF to monitor and support actions linked to COPD, hypertension and diabetes. Evidence showed 90% of patients with long term conditions had been reviewed and received treatment. This was above the CCG average.

The practice carried out regular referrals reviews and reviewed the consequent discharge letters. The practice also sought the input of the patient participation group (PPG), patient surveys, and comments, to gauge the needs of this group.

The practice carried out carers checks and maintained contact with carer's groups in line with an agreement with Devon County Council.

However, the practice had not carried out an infection control audit since August 2013 and this may put patients at higher risk of infection. In addition, staff told us that at times they weren't sure who to approach with issues. This called into question the leadership at the practice.

Requires improvement



Summary of findings

Families, children and young people

The practice is rated as requires improvement for families, children and young people. The number of patients in this population group was well below the national average.

The practice waiting room had a children's play area with wipe clean toys and some books for the entertainment of children whilst they waited for an appointment. Regular clinics were run by the local midwife.

Immunisation data showed that the practice carried out child hood immunisation vaccinations and six week health checks. These figures were comparative with other practices in the CCG.

The practice supplied travelling health advice for young families and recorded this in its clinical reporting system. The practice also supplied contraception and family planning advice linked to QOF actions in order to achieve national targets.

The practice sought the input of the PPG, patient surveys and comments, to gauge the needs of this group.

The practice had a system in place for the recording and flagging up of children with safeguarding issues. These were discussed and acted upon at monthly meetings or more frequently if required.

However, the practice had not carried out an infection control audit since August 2013 and this may put patients at higher risk of infection. In addition, staff told us that at times they weren't sure who to approach with issues. This called into question the leadership at the practice.

Requires improvement



Working age people (including those recently retired and students)

The practice is rated as requires improvement for providing care to working age people.

The practice supported patients in this population group through the provision of daily walk in clinics which did not require a booked appointment. These were held at the start and at the end of the working day.

The practice offered relevant advice to help patients return to work following sickness or if they were disabled. The practice offered guidance on pertinent adaptations to patient's work places and environment if required. The practice offered this on a case by case basis in order to help patients with their individual needs.

The practice had offered patients advice on the latest DVLA guidance about driving under the influence of medication which was relevant to this population group.

Requires improvement



Summary of findings

The practice used of the input from the PPG, surveys and comments, to gauge the needs of this group. The practice had also referred patients in this group to occupational health specialists when required.

The practice offered in house physiotherapy referrals. This included treatment space for patients to see physiotherapists therefore avoiding them having to travel to Okehampton hospital. Thus making it more accessible. We saw a physiotherapists working in a treatment room at the practice on the day of our inspection. Other relevant support to patients in this population group included smoking cessation clinics.

The practice website invited patients over 45 to arrange to have a health check with a healthcare assistant if they wished. These figures were comparative with other practices in the CCG. A cervical screening service was available.

However, the practice had not carried out an infection control audit since August 2013 and this may put patients at higher risk of infection. In addition, staff told us that at times they weren't sure who to approach with issues. This called into question the leadership at the practice.

People whose circumstances may make them vulnerable

The practice is rated as requires improvement for people whose circumstances may make them vulnerable.

The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at the multi-disciplinary team meetings. The practice aimed to identify people with vulnerable conditions as soon as possible and to offer them appropriate care available through the provision of complex care team's services.

The practice maintained a register of patients with learning disabilities and offered these patients an annual health check during which their long term care plans were discussed with the patient and their carer if appropriate. The practice liaised with learning disability nurse specialists to ensure effective communications.

The practice had a number of initiatives to avoid unplanned hospital admissions for patients. This included maintaining an active register of the 2% of patients most at risk. The practice met up on a monthly basis to discuss related actions and reported regularly on this to the clinical commissioning group (CCG).

The practice carried out monthly referrals reviews which helped to achieve appropriate treatment for this group. Quarterly audits were carried out and appropriate actions undertaken where required.

Requires improvement



Summary of findings

The practice liaised with social services on specific and individual cases where appropriate. The practice offered health checks at home to patients with access or mobility problems.

However, the practice had not carried out an infection control audit since August 2013 and this may put patients at higher risk of infection. In addition, staff told us that at times they weren't sure who to approach with issues. This called into question the leadership at the practice.

People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for providing care to people experiencing for mental health.

Over the last year, the practice had enhanced the identification and care of people with poor mental health and dementia. This had resulted in close monthly liaison with multi-disciplinary complex care teams to deliver co-ordinated care for patients in this population group. Written minutes of meetings confirmed this.

The practice used a computer system with a dementia screening tool in order to improve the identification of people with dementia or at risk of dementia.

The practice used the IT systems to identify and closely monitor patient care for people with mental health needs, including those with dementia. This helped GPs to carry out referrals reviews and signposting to support services.

The practice acted on feedback to support patients in this population group. For example, a complaint had raised the issue of mental health patients having a designated lead GP. A patient with a mental health issue was being dealt with by more than one GP in the past. This system had been reviewed and had resulted in patients now being allocated to a sole GP to ensure continuity of care.

The practice maintained liaison with social services on specific and individual cases and recorded this in the patient recording system.

Missed appointments for patients in this population group were reviewed and followed up. There was relevant information available to patients. The practice referred patients who needed mental health services as well as support services being provided at the practice.

Patients suffering poor mental health were offered annual health checks and testing for depression and anxiety as recommended by

Requires improvement



Summary of findings

national guidelines. GPs and nurses had training in the Mental Capacity Act (MCA) 2005 and an understanding of how to apply the principles. There was appropriate guidance available for staff in relation to the Act when caring for patients with dementia.

However, the practice had not carried out an infection control audit since August 2013 and this may put patients at higher risk of infection. In addition, staff told us that at times they weren't sure who to approach with issues. This called into question the leadership at the practice.

Summary of findings

What people who use the service say

We spoke with five patients during our inspection. We spoke with a representative 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 experience with us. We collected 17 comment cards which contained detailed positive comments.

Comment cards stated that practice staff were kind and welcoming and took the time to listen effectively. Comments also highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was positive. Patients told us

about their experiences of care and praised the level of care and support they said they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment.

Patients were happy with the appointment system and the walk in surgeries provided on a daily basis. Patients said it was easy to make an appointment. Patients appreciated the service provided and told us they had no complaints but understood the process should they wish to do so.

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

Patients told us they found the practice dispensary convenient and helpful and that they found it easy to get repeat prescriptions. Patients said they thought the website was useful.

Areas for improvement

Action the service **MUST** take to improve

The practice had recently undergone a transfer in ownership from one GP to another GP. As a result the staff expressed a lack of clarity in the leadership of the practice. The provider must ensure visible leadership at the practice on a regular basis in order to support good governance and to monitor risks at the practice.

Action the service **SHOULD** take to improve

The most recent infection control audit had been undertaken in August 2013. The provider should ensure that a comprehensive infection control audit is carried out on an annual basis.

Outstanding practice

In this rural farming area of mid Devon, the practice nurse reached out to a hard to reach group in the local population, the local farmers. This was achieved by regularly organising and staffing a stand in the local weekly village market, offering blood pressure checks and health advice to patients. This service had been provided for over five years. Without this service, local farmers, who cannot easily take time off work sick or visit a GP practice, would find it very difficult to access these positive health promotions. At the most recent market day screening, 26

patients had been seen. Of these patients, three had elevated blood sugars and three had elevated blood pressure. All patients were given healthy eating and lifestyle advice. Patients who recorded scores of elevated blood sugars or blood pressure were booked an appointment for future monitoring. Patients not registered at the practice who recorded elevated scores were advised to consult their own GP practice for future monitoring.

Hatherleigh Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor and a practice nurse specialist adviser.

Background to Hatherleigh Medical Centre

Hatherleigh Medical Practice provides primary medical services to people living in Hatherleigh and the surrounding areas. The practice provides services to a primarily older population and is situated in a rural location.

At the time of our inspection there were 2,035 patients registered at the practice. Two GPs were in the process of registering their partnership. One GP held managerial and financial responsibility for running the business. There were three salaried GPs. Four GPs were male and one was female. There was one practice nurse and one health care assistant and one phlebotomist at the practice. In addition there was a practice manager, and additional 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.

Hatherleigh Medical Centre is open between Monday and Friday: 8.00am until 6.30pm. Appointments were available from 8.30am until 6.30pm. Outside of these hours a service is provided by another health care provider by patients dialling the national 111 service. On a Wednesday the

practice closed at 1pm due to staff training and meetings. On a Friday the practice closed at 4pm. If patients wished to see a nurse or GP after 1pm on a Wednesday or after 4pm on a Friday they would visit a neighbouring practice which had an agreement with Hatherleigh Medical Practice for this purpose.

Between 9am until 10.30am and between 4pm until 5pm the practice runs an open surgery whereby patients are able to walk in and wait to a nurse or GP without a pre booked appointment.

The practice had also extended its hours around the Christmas holiday period so that it had been open on five weekends in December 2014 – January 2015. This had been due to an anticipated increase in patient demand during the winter.

Outside of these hours a service is provided by another health care provider by patients dialling the national 111 service. The practice provided services under a personal medical services contract with the NHS.

Routine appointments are available daily and are bookable up to three months in advance or further into the future according to the patient's wishes. Urgent appointments are made available on the day and telephone consultations also take place.

Hatherleigh Medical Practice was the main site and there were no branch practices. The address from which regulated activities were provided from this location was Hatherleigh Medical Practice, Oakfield Road, Hatherleigh, Okehampton, Devon EX20 3JT.

Detailed findings

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 Hatherleigh Medical Centre we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

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

We carried out our announced visit on Wednesday 15 April 2015. We spoke with five patients and eight staff at the practice during our inspection and collected 17 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, two GPs,

receptionists/clerical staff, practice nurses and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with a representative from the patient participation group (PPG).

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

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

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. The practice held monthly significant event meetings. Any staff were able to attend these meetings. The practice used an approved clinical commissioning group (CCG) template to record significant events. The practice produced written records of three significant events which had taken place in the last 12 months. Two of these events originated in the dispensary due to errors with the handling of the medication. This had been immediately rectified and the patient notified. None of the significant events had produced any significant adverse outcomes. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. For example, findings from these events had not been shared with other health professionals outside the practice to enable shared learning.

There was evidence that some appropriate learning had taken place and that the findings were communicated to relevant staff. For example, an incident had occurred where a GP had written a prescription which they had then cancelled, which was still dispensed by the dispensary. Learning points which had arisen from this included an improvement in the communication between the GPs and the dispensary.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. Staff we spoke with felt able to raise a concern. Staff told us that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

The practice manager was responsible for disseminating the information from these alerts to relevant staff. This was done via email and verbally at this small practice.

Learning and improvement from safety incidents

At Hatherleigh Medical Practice the process following a significant event or complaint was both informal and formalised. GPs met informally and discussed incidents daily and also three monthly at clinical meetings. GPs, nurses and practice staff were able to explain the learning from these events. However, these meetings had not been minuted precisely.

For example, a previous complaint had raised the issue of mental health patients having a designated lead GP. A patient with a mental health issue was being dealt with by more than one GP in the past. This system had been reviewed and had resulted in patients now being allocated to a sole GP to ensure continuity of care.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients, young patients and children. This GP was trained to level three in safeguarding and reflected current practice. However, the named safeguarding lead only attended the practice one day a week. Another GP at the practice was also trained to level three.

There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them.

There were monthly multidisciplinary team meetings with other community health professionals including social workers, district nurses, palliative care, physiotherapist and occupational therapists where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings and agree any necessary actions.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult or 'at risk' child had been

Are services safe?

seen by different health professionals, staff were aware of the patient's circumstances. Staff had received safeguarding training within the last 12 months and were aware of who the safeguarding leads were. Staff also demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or safeguarding policy.

The practice had carried out a safeguarding audit in March 2014 for NHS England. This audit examined how the practice performed in areas such as training, policies and systems in place. The practice had scored green on a risk assessment of red, amber or green. Green met current practice.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they felt one was required.

The practice had a written policy and guidance for providing a chaperone for patients which included expectations of how staff were to provide assistance. Nursing staff and health care assistants who had received chaperone training at the practice acted as chaperones as required. They had also received criminal record checks via the disclosure barring service (DBS). They understood their role was to reassure and observe that interactions between patients and doctors were appropriate and record any issues in the patient records.

Medicines Management

This was a dispensing practice. The GPs were responsible for supplying medicines to their patients at this practice.

Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the surgery, send an e-mail, or use the on-line request facility for repeat prescriptions.

In the practice dispensary we found that the keys to the controlled drugs cabinet and also the storage cupboard for blank prescriptions were not being stored securely when not in use. These arrangements were changed on the day of our inspection and the keys stored more securely.

We found the vaccination fridge was unlocked in an unlocked treatment room. This was secured and security arrangements including written protocols were reviewed on the day of our inspection.

We looked at the storage facilities for refrigerated medicines, the refrigerator plug was not easily accessible therefore was very unlikely to be switched off. Those medicines which required refrigeration were stored in secure fridges. Fridge temperatures were monitored daily to ensure that medicines remained effective.

All of the medicines we saw were in date. Storage areas were clean. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. Controlled drugs were stored securely and appropriately. Controlled drugs registers were kept up to date and audited regularly.

Patients were informed of the reason for any medicines prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medicine to check for side effects.

The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patient's medicines were authorised by the prescriber.

The practice was part of the dispensing services quality scheme (DSQS) with NHS England. This meant that the practice had approved standard operating procedures in line with current practice. NHS England had assessed the practice's dispensing arrangements within the last 12 months and found them to be satisfactory.

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they received. We received 17 completed cards. Of these, five specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands.

The practice had policies and procedures on infection control which had been reviewed within the last 12 months. We spoke with the infection control lead nurse. Staff had access to supplies of protective equipment such

Are services safe?

as gloves and aprons, disposable bed roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control.

The practice held quarterly infection control meetings. Attendees included the nurses, health care assistant and practice manager. Actions from these meetings were recorded and had been acted upon. For example, the provision of hand gel at the reception desk. The most recent infection control audit had been undertaken in August 2013. The provider should ensure that a comprehensive infection control audit is carried out on an annual basis. The lead infection control nurse told us they planned to complete this within the next month.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out and monitored daily. There were hand washing posters on display to show effective hand washing techniques. Hand washing training had taken place for all staff. Anti-bacterial hand gel was available for patients and visitors at reception. Hand washing facilities were also available in patient toilets.

Clinical waste and sharps were being disposed of in safely. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment available to the practice was within the expiry dates. Required emergency medicines were in place and in date. Emergency oxygen was in place. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in February 2015.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well.

The practice had a low turnover of staff. The majority of staff at this small rural practice had worked there for several years. GPs told us they covered for each other during staff absences.

The practice used a team approach where the workload for part time staff was shared equally. There was an administration team of six members of staff. Staff explained they had a strong team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal record checks via the disclosure barring service (DBS), had been performed for GPs and other clinical staff at the practice. Chaperone duties were carried out by clinical staff who had received a DBS check. However, administration roles had not received a formal written risk assessment.

The practice had a human resources policy in place which included disciplinary procedures to follow should the need arise.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan that documented the practice's response to any prolonged events that may compromise patient safety. For example, this included computer loss and lists of essential equipment. The plan had been reviewed in October 2014 and was due for review annually.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

Are services safe?

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had also been included on the basic life support training sessions. All staff had received this training in November 2014.

Staff were aware of the emergency assembly point in the car park, which was clearly signposted. Staff had received fire evacuation training in November 2014. A fire consultancy company had completed a fire audit of the site in October 2014 and serviced the fire equipment at the practice. This was carried out on an annual basis. A fire evacuation drill had been undertaken in November 2014.

The practice had an automated external defibrillator (AED). An AED is a device which assists patients suffering a cardiac arrest. Records showed that the battery for the AED was checked on a fortnightly basis. Current practice guidance recommends that this should be checked on a daily basis.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

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 Care Excellence (NICE) guidance and had formal meetings to discuss latest guidance. Where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area.

For example, the practice nurse worked closely with the local diabetes specialist at the Royal Devon and Exeter Hospital to support patients. The QOF scores for monitoring diabetic patients with high blood pressure were excellent. The target was to ensure that 90% of patients with diabetes had less than 150/90. The practice had achieved 98.1% which was higher than other practices in the CCG.

Through effective liaison by the practice with this hospital diabetic specialist, patients did not need to visit the hospital but still received advanced specialist care.

Management, monitoring and improving outcomes for people

The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including immunisation, diabetes care, cervical screening and travel vaccinations. The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The

QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for diabetes were consistently above the national average.

The practice carried out frequent COPD, diabetes and heart failure QOF searches and reached out to patients with these conditions by offering them health checks and appropriate treatment. In all of these areas the achievement in the practice has been higher than 90 % of the maximum QOF points.

Practice data from the CQRS (Calculating Quality Reporting NHS Service) March 2015 submission showed that there of the six new patients diagnosed with cancer over the last year, all had been reviewed by their practice GP within three months of their initial diagnosis during secondary care. This met CCG targets.

The practice maintained a register of patients with dementia. All 11 of these patients had been invited for a face to face review with their named GP. 10 of these had been completed and a reminder sent to the 11th. These 11 patients were monitored in order to avoid their unplanned admission to hospital. Their named GP carried out a review of their cases on a monthly basis.

The practice had 159 patients registered with diabetes. These patients had a six monthly review with the practice nurse, with bloods taken prior to that review. The nurse had discussed with them their condition, medication, test results and medication and explained any side-effects. A specialist diabetic clinician visited the practice from the local hospital to see patients with complex needs in tandem with the GP. During the review the GP checks blood pressure, cholesterol and other tests for the side effects of diabetes. New patients with diabetes were encouraged to attend a structured educational program.

The GPs referred patients to staff in the complex team, who provided support in the patient's home for treatment and rehabilitation. The team included physiotherapists, community nurses, matron and hospice nurses for palliative care. This enabled patients to receive a complete care and treatment package according to their individual need. This also helped to avoid unplanned hospital admission where appropriate for patients with complex needs.

Are services effective?

(for example, treatment is effective)

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and national institute of health and clinical excellence (NICE) guidance. The staff were appropriately trained and kept up to date with the latest developments in this field.

There was evidence of clinical audit in this area which was used by GPs for revalidation and personal learning purposes. GPs carried out six monthly clinical audits of minor surgical procedures. Within the last 12 months we saw that seven patients had undergone minor surgical procedures, for example, skin tag removals and knee injections. Of these, six had a 100% successful resolution and the patient was satisfied. One had experienced a 50% improvement and was due to be reviewed within six months.

The clinical auditing system used by the GPs assisted in driving improvement. Examples of audits within the last 12 months included a minor procedures, treatment, outcomes and follow ups audit. This audit had been undertaken to monitor the quality of the treatment offered in the practice. The audit had found that the best outcomes were achieved in cases when there was a follow up on the phone or face to face with the patient two weeks after the procedure had been completed.

Another audit had been carried out on the urgent care provided in this small practice compared with other small practices across Devon. The reason for this audit was the wide variation of patients being referred to hospital across the practices in Devon. The audit found that differences in the arrangements to see patients and distance to the nearest hospital could explain the variances of patients being sent to hospital.

One of the medicine audits at the practice had examined the prescribing of rosuvastatin. The reason for this audit was that historically, Hatherleigh Medical Centre has been a high prescriber of rosuvastatin, which is an expensive statin for high cholesterol treatment, compared with other practices. The findings of the audit had led to an analysis and review of the patients individually and their medication corrected accordingly.

All GPs were able to share examples of audits they had performed. These examples included minor surgery audits,

prescription audits, and medication audits. Audits followed a complete audit cycle and were readily available on the practice computer system to provide a resource for trainees and other staff.

Other evidence of audits included a dispensary audit February 2015 which had sought feedback from 50 patients on the dispensary arrangements at the practice. 47 of the 50 patients were very happy with the service, the remaining three were happy. Patients had requested online ordering of their prescriptions and this had been implemented by the practice.

The practice conducted ten carer's reviews every year. This involved an extensive review of each carer's needs and led to an outcome of referral for example to the Alzheimer's Society, psychological support or other appropriate service. The service included house assessments which examined whether any adaptations to promote a patient's independence were required. In addition, advice on financial support was also available.

Effective Staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. The lead GP had been appraised and revalidated in March 2015.

Nursing staff had received an annual formal appraisal and kept up to date with their continuous professional development programme, documented evidence confirmed this. A process was also in place which showed clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for each staff role. We spoke with a new member of staff who told us they had been fully supported during their induction. New members of staff were allocated a mentor for the first three months following their recruitment.

The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff said that they could ask to attend any relevant external training to further their development, such as additional dispensary training which had been requested and provided.

Are services effective?

(for example, treatment is effective)

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

The practice worked effectively with other services. Examples given were the complex care team based at the practice, mental health services, health visitors, specialist nurses, hospital consultants and community nursing.

For example, the GPs met with a diabetic consultant to discuss complex diabetic cases and worked with community psychiatric nursing teams when caring for patients with mental illness.

Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, 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.

Communication with the out of hour's service was good. One of the GPs completed extra shifts for the out of hour's service in order to expand their knowledge about the system. The practice GPs were informed electronically when patients were discharged from hospital. This prompted a review by the GP with their patient.

Information Sharing

The practice worked effectively with other services. Examples given were the complex care team, mental health services, health visitors, specialist nurses, hospital consultants and community nursing staff. For example, the GPs shared relevant information with health visitors regarding children in need and monitored actions taken.

Staff had received appropriate training on their responsibilities on the Data Protection Act 1998 in order to protect confidential patient information. Staff had completed annual training on information governance in March 2015 and this evidence had been sent to NHS England.

Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback given on our

comment cards showed that patients had different treatment options discussed with them, together with the positive or possible negative effects that treatment can have.

There was an electronic method of recording patient consent to treatment on the practice computer system. There was evidence of patient consent for procedures including immunisations, injections, and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject. We were given specific examples by the GPs where they had been involved in best interest decisions and where they had involved independent mental capacity assessors to ensure the decision being made regarding the patient who could not decide themselves, was in the patient's best interest.

Health Promotion and Prevention

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. A full range of routine screening tests were offered for diseases such as cervical cancer and ovarian cancer.

Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Follow up letters had been sent by the practice to the parent or guardian of children who missed their vaccinations.

In the 2 year old age group, there were 22 patients on the register. The practice had achieved 98.86% which was higher than the QOF target of 90%. In the 5 year old age group, there were 18 patients on the register. The practice had achieved 72.2% which was higher than the QOF target of 70%.

Figures for cervical smears showed similar success at the practice. In 2015, 102 cervical smears had been completed which was an achievement of 89.2%. This was above the QOF target of 80%.

Are services effective?

(for example, treatment is effective)

Patients were encouraged to adopt healthy lifestyles and were supported by services such as chronic disease clinics, diabetes and stop smoking advice. There was a wide range of other support services the practice referred patients to, such as a gym referral scheme in Okehampton.

All patients with learning disability were offered a physical health check each year. Of the 16 patients with learning disabilities registered at the practice, 10 had received health checks so far this calendar year and contact had been made with the remaining six to arrange a health check.

The practice had 298 registered smokers. 294 of these had recorded offers of support from the practice which included literature, counselling and referral to support services. Out of 298 smokers, 75 had long-term conditions. Records showed that all 75 of these had a record of being offered treatment and support for their long term conditions.

The practice questionnaire for new patients included questions about alcohol consumption. The practice had a register which showed 33 new patients had been offered further support if needed.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

There was a range of leaflets and information documents available for patients within the practice and on the website. There was a comprehensive tray system which contained leaflets on a wide range of ailments and conditions in alphabetic order from A-Z. These included addictions, bowel problems, cancer, ear nose and throat, depression, sexually transmitted infections and travel vaccinations. There was also information displayed on noticeboards about carer's support groups, children's activity groups, family health, long term conditions and minor illnesses.

Family planning, contraception and sexual health screening was provided at the practice. We saw contact details for sexual health screening displayed in the patients' toilet.

The practice offered travel vaccination advice and was able to signpost patients to the nearest travel vaccination centre in Exeter.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our visit we spent time talking with patients in the waiting room and in a private room. Patients told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff and spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received or about the staff, all comments were very positive.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 17 completed cards which contained very detailed positive comments. All comment cards stated that patients were grateful for the accessibility of the service and the caring attitude of the staff.

There was no evidence that any patients had been discriminated against. Patients told us staff were sensitive and supportive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The waiting room had sufficient seating and was located though a door away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. A radio played in the waiting room. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who is present with a patient during consultation, examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Staff understood their role was to reassure and observe that interactions between patients and GPs were appropriate.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an on-going dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and on-going care arranged by practice staff.

We were given specific examples where the GPs and nurses had taken extra time and care to diagnose complex conditions. Patients could book double appointments if they wished to discuss multiple conditions. This facility was also available to families who wished to attend together.

Patient/carer support to cope emotionally with care and treatment

The national GP – patient survey 2014-15 information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, patients could successfully request to speak with a particular GP. Of the 121 patient survey respondents 83% had seen or spoken to their preferred GP. This was higher than the CCG average of 71%.

In the same patient survey 99% of the 121 respondents said the last nurse or GP they saw or spoke to was good at treating them with care and concern. The patients we spoke to and the comment cards we received were consistent with this information.

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. On the day of our inspection there were 52 carers registered with the practice. Annual health checks had been offered to these patients of whom 11 had accepted and 24 had declined. The practice was awaiting responses from the remainder.

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. A personalised condolence card was sent from the practice. There was a counselling service available for patients to access.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours. Patients said they had not experienced delays receiving test results.

A patient participation group (PPG) had been set up over two years ago. We spoke with a member of this group who attended the practice during our inspection. They told us that PPG members were keen to become involved at the practice and said they had already been consulted about a new GP arriving at the practice.

The PPG member said they were encouraged to contribute suggestions at their monthly meetings with the practice. For example, the PPG had requested in April 2014 that the practice employ a female GP. The practice responded to this through the successful recruitment of a female GP in November 2014.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. Daily walk in clinics at the practice helped to ensure this.

The number of patients with a first language other than English at this small rural practice was very low and staff said they knew these patients well and were able to communicate well with them. 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. Staff at the practice spoke several different languages. Patients had a choice of male or female GPs.

The patient participation group (PPG) were working to recruit patients from different backgrounds to reflect each of the six different population groups.

General access to the building was good. There was level access and the practice was based entirely on the ground floor. The practice had a waiting room which was separate to the reception desk and had sufficient seating. Both the reception area and waiting room had sufficient space for wheelchair users. All consulting and treatment rooms had level access.

The practice had obtained guidance on different methods of communication with patients. For example, information was available in different font sizes and in picture format. There was no evidence of discrimination when making care and treatment decisions.

Access to the service

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. Of the 17 comment cards we received, 10 specifically mentioned that they found the accessibility of the service excellent. The other 7 did not mention access. The 10 that did mention it explained that they liked the flexibility of the walk in clinic and not always having to book an appointment. All comments, discussions and feedback indicated that patients were happy with the arrangements for access.

Patients told us there was excellent access to appointments at the practice on a daily basis. Between 9am until 10.30am and between 4pm until 5pm the practice ran a walk in clinic whereby patients could walk in and wait to see a nurse or GP without a pre booked appointment. In this rural farming area patients told us they valued this accessibility during the day. There were no late appointments available after 6.30pm.

The results of the 2014-15 national GP patient survey for this practice show that 100% of 121 patient survey respondents found it easy to get through to this surgery by phone. This was higher than the CCG average which was 84%. Of the 121 patient respondents 95% described their experience of making an appointment as good. This was higher than the CCG average of 82%.

Are services responsive to people's needs?

(for example, to feedback?)

These findings were reflected during our conversations. Patients were happy with the appointment system and said they could get a same day appointment if necessary. All of the patients we spoke with commented on how much they valued the walk in clinic system at the practice.

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by posters displayed in the practice, on the website and on the telephone answering message.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. We saw there had been three complaints in the past 12 months. The practice manager was the lead for dealing with complaints, referring to GPs for any clinical advice required. All of these had been dealt with within the practice policy timescales.

Patients told us they had no complaints and could not imagine needing to complain. Not all patients were aware of how to make a complaint but said they felt confident that any issues would be managed well.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the surgery welcomed patient opinion by sharing ideas, suggestions, views, and concerns.

The complaints procedure stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. The practice manager would seek a meeting with the patient making the complaint if the patient wished to do so. Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at the staff meetings held every month and at clinical meetings every six weeks.

Since the inspection, the practice had held two staff meetings, in which all staff discussed the more negative feedback on the NHS Choices website. We were provided with the written minutes of these meetings. The practice lead GP had contacted NHS Choices in order to enable the practice to leave messages in response to patient feedback. Where the individuals wished to do so, the lead GP had met with them to discuss ways to make improvements.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice vision was to provide continuity of care, preserving the advantages of a small local practice, delivering high quality care and to ensure good team working at the practice with other neighbouring practices.

Staff spoke positively about communication, team work and their employment at the practice. They described the practice as having an open culture and being a good place to work. There was a stable staff group and many staff had worked at the practice for many years and was positive about the open culture.

We were told there was mutual respect shared between staff and that they appreciated the team work at the practice.

Staff said the practice was small enough to communicate informally through day to day events and more formally through meetings and formal staff appraisal. The practice held staff meetings every month. We saw the agenda for the March 2015 meeting. Items discussed included NHS Health checks for 40-74 year olds, carers register, significant events and complaints.

Governance Arrangements

Staff received information governance training on an annual basis and had received it within the last 12 months. Staff said that governance systems used were both informal and formal. Issues were discussed amongst staff as they arose, for example, at the March 2015 staff meeting the items discussed included the business continuity plan and dispensary arrangements. However, staff were not always sure who to approach with issues. The leadership structure at the practice was changing and the lack of clarity engendered risk to continuity of governance systems and monitoring of risk.

GPs discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. These issues were then followed up more formally at six weekly clinical meetings where standing agenda items included significant events, NICE guidance updates, complaints and health and safety.

We reviewed a number of policies, including disciplinary procedures and induction policy which were in place to

support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The practice was in the process of a transfer in ownership. Some staff felt unsupported by the new leadership due to an infrequent physical presence of the new GP at the practice. The new GP had not consistently attended the practice on a weekly basis. The reasons being were that they also had work commitments at a children's hospice and out of hour's service provision. As a result the staff expressed a lack of clarity in the leadership of the practice. In order to feel better supported staff told us they would like to see the new provider at the practice in person at least on a weekly basis, if not more frequently. Following our inspection the practice have informed us that the new lead GP spends two days per week at the practice. This included one clinical day and one administrative day.

Practice seeks and acts on feedback from users, public and staff

Patients we spoke with in the waiting room were aware there were suggestion boxes in the waiting room and at reception. The website signposted patients to give feedback if they chose. The practice acted upon patient feedback and we saw several examples of this.

For example, feedback had been received concerned that a patient with a mental health issue was being dealt with by more than one GP. This system had been reviewed and had resulted in patients now being allocated to a sole GP to ensure continuity of care. The informant had been satisfied with the outcome.

The practice had a patient participation group (PPG), which had been set up over two years ago. The PPG was advertised on the website.

We spoke with a member of the PPG. There were approximately 12-15 members. The PPG was working towards recruiting members from each of the population groups. The PPG met up once every three months. The PPG member who came to the inspection said the practice manager and GP representative were keen to encourage patient feedback and involvement.

Are services well-led?

Requires improvement 

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

The PPG said that they were consulted about how the practice was progressing and had already been consulted about a new GP joining the practice. The practice listened to the views of the PPG and acted upon their suggestions. The PPG told us that the practice had a high level of accessibility and patients could always see a GP when they wanted to. This was as a result of the daily walk in clinics at the practice.

The PPG conducted an annual survey with patients at the practice. The results of this survey were recorded on the website. The December 2014 patient survey showed high levels of satisfaction with the practice.

Management lead through learning & improvement

A process was followed so that learning and improvement could take place when events occurred or new information was provided. For example, the practice held monthly staff meetings to discuss any current topics and review any newly released national guidelines and the impact for patients. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

For example, storage of information on the shared drive computer system had been discussed and reviewed following an incident with blood test results. Following this, communication between staff regarding test results had been improved.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

There were environmental risk assessments for the building. For example, annual fire assessments which last took place in November 2014, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been carried out. Health and safety items were an agenda item for the monthly staff meetings. The safety of the window blinds had been discussed in March 2015. The blinds had been replaced with a safer set of blinds within a week of the meeting.

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

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

The registered person must promote a culture that encourages candour, openness and honesty at all levels. The regular presence of the registered person at the practice supports staff in achieving this.

The registered person must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in the carrying on of the regulated activity against the requirements set down in this part of the regulations. Regulation 20(1).

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

The registered person must, so far as reasonably practicable, ensure that service users, persons employed and others who may be at risk of exposure to a health care related infection arising from the carrying on of the regulated activity are protected against identifiable risks of acquiring such an infection by - (2) (a) the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infection.

The most recent infection control audit had been undertaken in August 2013. The provider should ensure that a comprehensive infection control audit is carried out on an annual basis.