Moretonhampstead Health Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Moretonhampstead health centre was inspected on Thursday 6 November 2014. This was a comprehensive inspection.

Moretonhampstead health centre provide a primary medical service to approximately 3,000 patients of a diverse population age group in the rural town of Moretonhampstead close to Dartmoor national park.

The practice also holds branches at three remote villages in the surrounding rural area. These branch surgeries are located in the villages of Lustleigh, Manaton and Bridford but were not inspected on this occasion.

There was a team of three GP partners. GP partners hold managerial and financial responsibility for running the business. In addition there were two registered nurses, one health care assistant, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, school nurses, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

We rated this practice as good.

Our key findings were as follows:

The practice was well led and responded to patient need and feedback. Innovative and proactive methods were used to improve patient outcomes even where no financial incentives or contractual agreements were expected.

The practice had an active patient participation group which had identified the need for coordinated services locally in partnership with the GPs and health care professionals.

Patients reported having good access to appointments at the practice and liked having a named GP which, they

Summary of findings

told us, improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

Feedback from patients about their care and treatment was consistently positive. We observed a non-discriminatory, person centred culture. Staff told us they felt motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

The practice was well-led and had a leadership structure in place, staff displayed a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of mental capacity to make decisions about care and treatment, and the promotion of good health.

Suitable recruitment, pre-employment checks, induction and appraisal processes were in place and had been carried out thoroughly. There is a culture of further education to benefit patient care and increase the scope of practice for staff.

Documentation 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.

Patients felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was implemented and communicated to show what learning, actions and improvements had taken place.

We saw an area of outstanding practice relating to patient access:

The practice were responsive to the needs of patients and provided services even when the service provided is not included in the GP contract. For example the GPs had recognised that some patients travelled a long distance in the rural setting, often with no links to public transport.

- The GPs has worked with the supplying pharmacist to ensure medicines and prescriptions could be collected and delivered to the branch surgery villages. For example, the GP who attended Lustleigh would take the medicines to the local post office for collection.

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

The provider should ensure that:

- The emergency equipment should be checked for expiry date.
- The practice should check the suitability of locum staff working at the practice. For example, there should not be an assumption that locum staff have provided evidence of indemnity insurance and General Medical Council (GMC) check.

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?

Good

The practice is rated as good for providing safe services.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent. Risk assessments were performed when a decision had been made not to perform a criminal records check on administration staff.

Significant events and incidents were investigated systematically and formally. There was a culture to ensure that learning and actions had been taken and communicated following such investigations, and staff confirmed their awareness.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005. Recent training had been provided for GPs and nursing staff. There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management of medicines within the practice.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both national institute for health and care excellence (NICE) guidelines and other locally agreed guidelines. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients.

The service provided and data showed that the practice is performing equally when compared to neighbouring practices in the CCG.

Summary of findings

Patient's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate and in addition to their roles. Effective multidisciplinary working was evidenced.

Regular audits of patient outcomes were performed and completed, which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes.

There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff.

The practice worked together efficiently with other services to deliver effective care and treatment and on occasions went above and beyond their contractual agreements to provide additional services for patients.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently positive. Data reflected this feedback.

We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. There were many positive examples to demonstrate how people's choices and preferences were valued and acted on. Accessible information was provided to help patients understand the care available to them.

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had initiated positive service improvements for their patient population that were over and above their contractual obligations, particularly for older patients, patients with long term conditions and carers. For example additional branch surgeries were held in three of the surrounding villages which did not have public transport links to Mortenhampstead. The GPs also worked with the local pharmacy to deliver medicines on the days branch surgeries took place in these villages.

Summary of findings

The practice was supported by a very active and diverse patient participation group (PPG) who helped with a number of the initiatives to benefit patients. The practice and PPG had responded to patient request and need and were in consultation to work with the local clinical commissioning group and health care professionals to provide a health and social hub where patients would be able to access a wide variety of health and social care services requested by the community.

The practice had also extended the appointment length from ten minutes to15 minutes so patients could discuss more than one condition, thus removing the need to travel to the practice on more than one occasion.

Patients reported good access to the practice and a named GP providing continuity of care. Urgent appointments were available within the same day. The practice had the facilities and equipment to treat patients and meet their needs.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning, by staff from complaints.

Are services well-led?

Good

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

The organisation was new with recently recruited partners and practice manager. Patients and staff alike said this transition had been smooth and had not caused any issues. Staff were clear about the vision of the organisation and their responsibilities in relation to this. The strategy to deliver the vision was clear and reviewed and discussed with staff. The practice carried out informal and formal succession and business planning. There was a leadership structure in place and all staff felt supported by management and each other. There was a stable staff group and high level of job satisfaction and support for nursing and clerical staff.

The practice had a number of systems, policies and procedures to monitor risk, clinical effectiveness and governance and to share learning from any events.

The practice valued and proactively sought feedback from patients and staff and this had been acted upon. The practice had an active patient participation group (PPG) which reflected the patient age range.

Staff had received inductions, regular performance reviews and had attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

Patients aged 75 and over at the practice have their own allocated GP, although they do have the choice to see any of the GPs.

Older patients had access to the full range of appointments at the practice. However, they could also

arrange an appointment at one of the branch surgeries if it is more convenient and closer to home.

Older people who have problems getting to the practice, who are housebound or are resident in local care homes had their vaccines administered at home by the community nursing team or by the GP. Home visits were undertaken by the GP and/or community nursing team for older patients following their discharge from hospital, or as required.

The Out of Hours service had been given access to patient's health and social care information, particualry older patients with more complex needs, in order to help maintain their care at home and avoid the need for hospital admission.

The practice worked hard to prevent unnecessary and avoidable admissions to hospital, and worked closely with other health professionals both in the community and secondary care. The GPs could contact the rapid access service (RAS), a local authority service set up to organise community care quickly, which assists with helping patients remain in their own home environment. The practice had a system to identify older patients who required a co-ordinated multi-disciplinary care plan. Treatment was organised around every individual patient and was specific to any conditions they may have. GP and Practice nursing team provided effective and regular monitoring of older patients who suffered from long term conditions.

The GPs attended a monthly multi-disciplinary meeting at which the planning and delivery of care to vulnerable patients with complex needs and for those patients approaching end of life, was discussed, planned and co-ordinated.

A full vaccination programme was provided at the practice either at the weekends, during the standard week day surgeries or at one of the three branch surgeries if it was more convenient and closer to the patient's home.

Summary of findings

The practice worked closely with a local organisation who help transport patients to appointments at the practice and hospital if required.

The practice was working closely with the local clinical commissioning group (CCG) and community health care professionals to develop a health and social hub which will provide services to support the older population.

The Practice was on one level for easy access. The internal entrance doors automatically opened by pushing a button.

The patient participation group (PPG) includes representation from the older patient group from the practice.

People with long term conditions

Good

The practice had systems in place to identify patients who may be vulnerable, have multiple or specific complex or long term needs.

Patients could arrange an appointment at one of the branch surgeries if it was more convenient and closer to home. This avoided repeated trips to the practice which may be difficult or inconvenient due to the rural location and lack of public transport. GPs undertook regular or ad hoc home visits as required. If appropriate home visits were undertaken jointly with the community nursing team.

Home visits and medication reviews were offered to all patients with long term conditions who have recently been discharged from hospital.

Patients with long term conditions were invited into the surgery for regular consultations and medication reviews and additional screening as necessary.

GP and Practice nursing team promoted the effective management of any long term conditions that a patient may have. Patients with long term conditions had tailor made care plans in place.

If patients were nearing the end of life the practice operated a system where 'just in case bags' were located in the patients home environment, this provided immediate access to medicines and equipment likely to be needed to assist with the management of their symptoms.

The practice worked with external health care professionals. to ensure advice and guidance was sought as required. The practice held a monthly multi- disciplinary meeting at which planning and delivery of care for patients with complex needs and long term conditions was discussed.

Summary of findings

The Practice nurse ran clinics with dedicated slots for the review of patients with diabetes, asthma and chronic lung conditions. Annual reviews with a qualified respiratory nurse were provided to those patients on the practice register who had asthma or chronic lung conditions. Personalised management plans were developed with the patient.

The GP and/or practice nurse attended a quarterly virtual diabetic clinic held in partnership with colleagues from the acute hospital to ensure treatment was in line with national guidelines. The nurses attended educational updates to maintain and develop their clinical knowledge.

The practice promoted independence and encouraged self-care for this patient group. For example, there was a blood pressure machine in the waiting area so patients could monitor their own blood pressure. Patients were encouraged to enrol on a weight management or smoking cessation programme where appropriate. The practice hads a referral arrangement with the local gym to provide free access and training programme delivery the first six sessions.

The practice identified patients who were carers and offered them support and health care checks.

Families, children and young people

Good

Women and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. Men were also able to get contraceptive advice, basic sexual health screening and chlamydia testing. A weekly contraceptive clinic took place for the fitting and removal of intrauterine devices (IUD's) and contraceptive implants. IUD fitting for emergency contraception was available as required at other times.

The practice promoted and offered a chlamydia screening programme specifically for young people.

Patients were able to book an appointment via an online appointment booking system and a telephone consultation was available for parents and guardians and young people.

Ante-natal care was provided by a visiting midwife and the GPs where appropriate. An ante-natal clinic took place at the practice every other week. The Midwife had access to a GP at every clinic.

A baby clinic run by a health visitor took place at the practice every other week. The health visitor had access to a GP at every clinic. A private area was provided for mothers who wished to breast feed their baby at the practice.

Summary of findings

The GPs carried out child health surveillance and post natal checks.

The practice offered childhood vaccinations as per the current NHS schedule and invited parents or guardians to those appointments.

The practice worksedwith the health visitor and school nursing team and was able to access support from childrens workers and parenting support groups where relevant. Meetings were arranged with the GP, Health visitor and school nursing team as required to discuss cases involving children and young people, including where parents do not attend appointments.

The PPG at the practice included representatives who were parents with young families.

Systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

There was a dedicated children's section of the waiting room, with toys that were regularly cleaned and a record for audit was maintained.

Working age people (including those recently retired and students)

Good

Appointments could be booked up to three months in advance. Early morning and evening appointments were available once a week to assist patients not able to access appointments due to their work times. Patients were able to book an appointment via an online appointment booking system or use the telephone consultation service if more convenient.

Patients could request repeat medicines via e mail, at the local pharmacy, or in person at the health centre. These were usually processed within 24 hours and could be collected from the health centre, pharmacy or sent by post.

The patient participation group at the practice included working age members.

Travel advice including up-to-date vaccinations and anti-malarial drugs were available from the practice.

Patients between the ages of 45 and 75 were invited to a well-being health check. For the other patients, staff offered opportunistic health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks including blood tests as appropriate, and reminders to have medicine reviews.

Summary of findings

Patients were encouraged to enrol on a weight management programme as appropriate. The practice offered referrals to the local gym to help support lifestyle change and weight loss.

People whose circumstances may make them vulnerable

Good

The practice had a vulnerable patient register and systems in place to identify vulnerable patients who may not be able to access primary medical care. This included patients who lived remotely with no access to transport. The practice had three branch surgeries held in village halls in surrounding isolated villages. This provided a more convenient service for patients living in the area. The practice worked closely with a local organisation who help transport patients to appointments at the practice if required.

The case notes of vulnerable patients were reviewed monthly at multidisciplinary team meetings.

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with them and their carer if appropriate. The GP visited these patients in their own home, to reduce stress and improve communication. The GP liaised with the local learning disability community nurses.

Health education, screening and immunisation programmes were offered as appropriate.

Practice staff referred patients with alcohol addictions to an alcohol service for support and treatment and to the local drug addiction service. Two of the GPs were trained in opioid addiction and replacement therapy, undertaking regular reviews of dependant patients and providing them with methadone prescriptions in line with guidelines.

Practice staff were able to refer patients to counselling services as appropriate. These support services visited the practice if the patient preferred this.

The practice worked with a community matron who visited any vulnerable patients to assess and facilitate any equipment, mobility or medicine needs they may have and to generally support the patient and their carers.

The practice had access to a food parcel service for patients if they were identified as experiencing significant financial hardship.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia).

Summary of findings

The practice had systems in place to identify patients with serious and enduring mental health problems. Each of these patients had a named GP and had received an annual physical health check.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Staff carried out advance care planning for patients with dementia.

Patients had access to counselling services provided by the depression and anxiety service (DAS). Patients who had depression were seen regularly and were followed up if they did not attend appointments.

In house mental health medicine reviews were conducted to help ensure patients received appropriate doses. Any patient taking specific medicines had regular blood tests to help ensure therapeutic doses were prescribed. .

Advice and support was sought from the community psychiatric team with patient referrals being made for a psychiatry review or entry into counselling. Patients were encouraged to refer themselves to a counselling service where appropriate.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection and three 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 46 comment cards, all of which contained positive comments. There were no negative comments.

Comment cards stated that patients appreciated the service provided, caring attitude of the staff and for the staff who took time to listen effectively. There were many comments praising GPs and nurses. Comments also highlighted a confidence in the advice and medical knowledge and praise for the continuity of care and for not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, very satisfied and said they had no complaints and got good treatment. Patients told us that the GPs and nursing staff were excellent.

Patients had been aware there had been some staff changes including of two long standing staff who had been very popular. Patients said the transition had been smooth and new staff had settled in very well.

Patients were happy with the appointment system and said it was easy to make an appointment and liked the convenience of being able to attend the rural branch surgeries. Patients appreciated the service provided and told us they had no concerns or complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice and 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 and said they thought the information provided and the practice website was good.

Areas for improvement

Action the service SHOULD take to improve

- The emergency equipment should be checked for expiry date.
- The practice should check the suitability of locum staff working at the practice. For example, there should not be an assumption that locum staff have provided evidence of indemnity insurance and General Medical Council (GMC) check.

Outstanding practice

- The GPs has worked with the supplying pharmacist to ensure medicines and prescriptions could be collected and delivered to the branch surgery villages. For example, the GP who attended Lustleigh would take the medicines to the local post office for collection.

Moretonhampstead Health 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 an expert by experience. Experts by Experience are people who have experience of using care services. They have first-hand experience of receiving care so they know which questions to ask to get as much information from the visit as possible.

Background to Moretonhampstead Health Centre

Moretonhampstead health centre provides primary medical services to people living in the rural town and surrounding villages of Moretonhampstead which is located on the edge of Dartmoor national park. The practice provides services to a diverse population and age group.

The practice also operates branches at three remote villages in the surrounding rural area. These branch surgeries are located in the villages of Lustleigh, Manaton and Bridford but were not inspected on this occasion.

There is a team of three GP partners. GP partners hold managerial and financial responsibility for running the business. In addition there were two registered nurses, one health care assistant, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, school nurses, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

Moretonhampstead health centre is open between 8.30am and 5pm Monday to Friday. The practice also offers early morning appointments on a Thursday and evening appointments on Tuesdays. These appointments are designed for patients unable to access appointments during normal office hours. Outside of these hours a service is provided by another health care provider.

Patients were offered a same day appointment on a first come first served basis. There is also a telephone request service for patients who just want to speak with a GP rather than visit. Routine appointments are bookable up to three weeks in advance.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before conducting our announced inspection of Moretonhampstead Health Centre, we reviewed a range of information we held about the service and asked other

Detailed findings

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 Thursday 6 November 2014. We spoke with ten patients, all three GPs, three nurses, the practice manager and five administration staff. We collected 46 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with three representatives 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

Good

Are services safe?

Our findings

Safe Track Record

The practice had a systematic, clear process in place for reporting, recording, monitoring, and communicating findings from significant events. The practice kept records of significant events that had occurred and used these as part of a quality assurance process to monitor any trends. There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff. Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that the regular three monthly significant event meetings were well structured and well attended by all representatives from each team. We spoke with a member of staff who had been involved in a significant event. They told us they had been supported very well, had been involved in the process and the event had been looked at from all angles to reduce it occurring again.

Learning and improvement from safety incidents

At Moretonhampstead Health Centre the process following a significant event or complaint was formalised and followed a set procedure. GPs discussed the incidents as they occurred an during their morning meeting, but also more formally at the three monthly meetings where actions and learning outcomes were discussed. We were given four clear examples of where practice and staff action had been prompted to change as a result of incidents. These included changes in protocols, additional training and support for staff and further communication for all staff.

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. They had been trained to the appropriate advanced level. There were policies in place to direct staff on when and how to make a safeguarding referral. This included flow charts displayed for staff reference. The policies and flow charts included information on external agency contacts, for example the local authority safeguarding team.

Staff were aware of their responsibilities regarding safeguarding vulnerable adults and children and said they felt able to report to the GP, manager or external agencies as required. There were formal meetings where vulnerable patients were discussed with relevant health professionals.

Practice staff said communication between health visitors, community nurses 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. Staff explained that the community, patient participation group, local clinical commissioning group and GPs were in the process of setting up a community social and healthcare hub at the hospital next door. We were told this would reduce the need for patients to travel for care and treatment and would further improve communication and care of vulnerable people.

The computer based patient record system allowed safeguarding information to be alerted to staff. Staff had received safeguarding training 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.

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

Medicines Management

The GPs were responsible for prescribing medicines at the practice. There was a dispensing pharmacy in the town.

The practice carried out clinical audits involving medicines and implemented good practice guidance around prescribing and medicines management.

The control of repeat prescriptions was managed well. 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

Good

Are services safe?

on-line request facility for repeat prescriptions. Patients particularly appreciated the deliver service to the villages where branch surgeries were located. The GP and pharmacy worked together to ensure patients who lived in rural areas were able to receive their medicines.

There were systems in place to ensure that all prescriptions were authorised by the prescriber, and that patient's medicines were reviewed regularly. The computer system allowed for highlighting high risk medicines, for checking for allergies and interactions and processes for more detailed monitoring.

Patients were informed of the reason for any medication prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness.

All of the medicines we saw were in date. All storage areas were appropriate, clean and well ordered. A new medicines cupboard had been installed to improve security. There were appropriate arrangements and records for the disposal of these medicines. Vaccines were stored appropriately in a hard wired fridge. There were auditing systems in place to ensure that the cold chain was maintained, ensuring that these products would be safe and effective to use. Other medicines kept at the practice for use by GPs and practice nurses were stored safely and systems were in place to monitor expiry dates. These checks included medicines stored in GPs bags.

Suitable emergency medicines and equipment were available at the practice, and systems were in place to make sure the medicines were checked and maintained regularly. We found the same level of checks were performed on the emergency equipment.

There were systems in place to make sure any medicines and medical equipment alerts or recalls were actioned by staff. There were systems to record any incidents occurring (or 'near misses') so that lessons could be learnt and procedures changed if necessary to reduce the risks in future.

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

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about their care and treatment. We received 46 completed cards. Of these, nine 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 included managing spillages, needle stick injury, waste, cleaning and control of substances hazardous to health. We spoke with the infection control lead nurse and lead GP who explained that the practice have a regular process of infection control audit and re audit. The most recent audit earlier in the month had identified and prompted the introduction of new waste bins and a change in the way specimens were stored and collected from patients. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out.

Clinical waste and sharps were being disposed of in safe manner. 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

The majority of emergency equipment available to the practice was within the expiry dates, although there was not a robust system in place to monitor expiry dates of equipment. The practice had an effective system using checklists to monitor the dates of emergency medicines which ensured 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 by an external contractor. The last test was October 2014.

Staff told us they had sufficient equipment at the practice.

Good

Are services safe?

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had experienced some recent staff changes which included a GP, practice nurse and practice manager. Patients and staff said despite the previous staff being very popular the new staff had settled in well. There was a low turnover of administration staff and many staff at the practice had been there for a number of years.

Recruitment procedures were in place and staff employed at the practice had undergone the appropriate checks prior to commencing employment. However, the same standard of checks was not used for locum staff. There was an assumption that all checks had been done. The new practice manager had not recruited any locum staff since she had been in post but gave assurances that checks of indemnity insurance, CV's and general medical council checks would be performed.

Once in post staff completed a job specific induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal records checks were only performed for GPs and nursing staff. A risk assessment had been performed explaining why clerical and administrative staff had not had a criminal records check.

The practice had disciplinary procedures to follow should the need arise.

The registered nurses' 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 their response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment.

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

There was a system in operation to ensure one of the nominated GPs covered for their colleagues, 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. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Administration staff appreciated that they had been included on the basic life support training sessions. Staff were aware of where to find this equipment.

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

Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. There were examples where care and treatment followed national best practice and guidelines. For example, the practice had an on line formulary to access guidance. Emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). We saw that 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.

The nurses told us they lead in specialist clinical areas such as diabetes, heart disease and asthma. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, nurses told us they were able to speak with the GPs at any time if they needed. The nursing staff also said the GPs approached them for advice and guidance on nursing matters.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. We saw systems used to ensure elective and urgent referrals were made within timescales.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice was using innovative and proactive methods to improve patient outcomes even where no financial incentives or contractual agreements are expected. For example the GPs had decided to extend appoinmet times from ten minutes to 15 minutes. They had recognised patients often needed to discuss more than one ailment and had travelled long distances to visit the practice. The GPs hoped the extension to appointment times would reduce multiple visits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). This practice was not an outlier for any QOF (or other national) clinical targets. The GPs used the QOF data to monitor the service they provided and also to improve and identify where additional services may be necessary. For example, providing additional clinics for patients.

The practice had a system to identify more vulnerable patients and the GPs were included in a local multidisciplinary team who met to discuss vulnerable patients, as well as those at risk. The team included community nurses, social workers, occupational therapists, physiotherapists and palliative care nurses.

GPs in the surgery undertook minor surgical procedures, such as removal of skin lesions, in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area, which was used by GPs for revalidation and personal learning purposes. For example one GP had performed an infection rate audit following insertion of contraceptive devices to ensure best practice was being followed.

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.

Good

Are services effective?

(for example, treatment is effective)

Nursing and administration staff had received an annual formal appraisal and kept up to date with their continuous professional development programme. We saw documented evidence to confirm that this process was used.

A process was in place to ensure clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for the role of each person.

The staff training programme was monitored to make sure staff were up to date with training the practice had listed as mandatory. This included basic life support, safeguarding, fire safety and information governance. Staff training was discussed at appraisal and staff could attend any relevant external training to further their development and benefit patient care. Practice nurses performed defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles in respiratory disease and asthma described the training that they had to fulfil these roles.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system. Staff were familiar of where to find these.

Working with colleagues and other services

There was evidence of working with other services. This included working with the multidisciplinary team to discuss vulnerable patients, meetings with palliative care and hospice care staff and individual communication with other health care professionals. This included physiotherapists, occupational therapists, health visitors, district nurses, midwives, community matrons and the mental health team.

Other examples of working with others included working with counsellors from the depression and anxiety service (DAS) and with mental health care professionals.

The practice were currently working with the local commissioning group (CCG), patient participation group (PPG) and health care professionals to set up a health and social care hub at the hospital next door. The GPs, practice manager and PPG have been actively been involved in influencing what services are to be introduced for the benefit of patints at the practice.

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 (a system to enable patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved for future reference.

Involvement in decisions and consent

Patients we spoke with 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 from the comment cards showed that patients had different treatment options discussed with them.

The practice used a variety of ways of recording patients gave consent depending on the procedure. These included pre populated computer records, free text and written consent. We saw examples of these 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 and had received training. We were given specific examples by the GPs where they had been involved in best interest decisions.

Health Promotion & Prevention

There were specific clinics held for patients with complex illnesses and diseases. This was used as an opportunity to discuss lifestyle, diet and weight management. A full range of screening tests were offered for diseases such as

Good

Are services effective?

(for example, treatment is effective)

prostate cancer, cervical cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. At the time of the inspection the flu clinics were being promoted in the waiting areas.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. All patients with learning disability and mental health illness were offered a physical health check each year. The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 14.5% of patients in this age group took up the offer of the health check.

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.

Patients were encouraged to adopt healthy lifestyles and were supported and the practice recognised the need to maintain fitness and healthy weight management.

There was a range of leaflets and information documents available for patients within the practice, in the toilets and on the website. These included information on domestic violence, sexual health, family health, travel advice, long term conditions and minor illnesses. The web site links were simple to locate.

Family planning, contraception and sexual health screening was provided at the practice.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with 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. Patients spoke highly of the staff and GPs. We did not receive any negative comments from patients or within comment cards about the care patients received.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 46 completed cards which contained very detailed positive comments. All comment cards stated that patients were grateful for the caring attitude of the staff who took time to listen effectively.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. Patients told us confidentiality was also respected at the branch surgeries which were held in village halls. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

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

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred, in their comments, to an ongoing 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 ongoing 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.

There were 21 patient comment cards which made reference to an improved appointment system now being used at the practice. Patients and the patient reference group representative said this change had occurred after feedback from patients. Patients said they had been involved in this decision and found it of benefit.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The practice survey information showed patients were positive about the emotional support provided and rated it well. For example, 91% of the 146 respondents in the March 2014 survey stated that they were treated with kindness and care. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this information. For example, these highlighted staff responded compassionately when patients needed help and provided support when required.

Notices in the patient waiting room and the practice website signposted patients 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.

The practice works closely with a local organisation who help transport patients to appointments at the practice and hospital if required.

Staff told us families who had suffered bereavement had access to a counselling service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with 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 patient who needed referral, including urgent referrals, for secondary care and routine health screening including cervical screening, were made in a timely way. Patients told us that their referral to secondary care had always been discussed with them and arranged in a timely way.

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. Results were reviewed within 24 hours, or 48 hours if test results were routine. Patients had not reported delays receiving test results.

The practice were responsive to the needs of patients and provided services even when the service provided was not included in the GP contract. For example, the practice had responded to feedback from patients about the difficulty getting to the practice and length of appointment time to discuss issues. The GPs had extended appointment times to 15 minutes to enable patients to discuss more that one issue thus reducing multiple trips to the practice. The GPs also held three branch surgeries at surrounding rural villages where public transport links were poor. The GPs had also recognised that patients found it difficult to obtain medicines from the pharmacy so the GPs worked with the pharmacy and took prescribed and dispensed medicines to these villages.

The practice had an active patient participation group (PPG) in place which reflected the age range of the patients. Members of this group were active in providing feedback about the services including involvement in the hub. The PPG members said they were encouraged to contribute suggestions and felt their views were valued.

Tackle inequity and promote equality

The number of patients with a first language other than English was 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.

There was level access to the entrance of the practice and all consulting rooms. There were automatic door openers at the practice and large accessible toilet facilities.The practice had an open waiting area, sufficient seating and sufficient space for wheelchair users.

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Access to the service

Moretonhampstead health centre is open between 8.30am and 5pm Monday to Friday. The practice also offers early morning appointments on a Thursday and evening appointments on Tuesdays. These appointments were designed for patients who were unable to access appointments during normal office hours. Outside of these hours a service is provided by another health care provider.

Patients were offered a same day appointmet on a first come first served basis. There is also a telephone request service for patients who just want to speak with a GP. Routine appointments bookable up to three weeks in advance.

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. Discussions and comment card feedback showed that patients were happy with the arrangements in place.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and staff stated it helped with communication.

Information about the appointment times were found on the practice website and within the practice. Patients were informed of the out of hours arrangements when the practice was closed by a poster 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. Patients told us they had no complaints and could not imagine needing to complain. Patients were aware of how to make a complaint.

The practice had website contained clear information on how patients could make a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Records were kept of complaints which showed that responses and investigations were timely and completed to the satisfaction of the patient. Records also included evidence of any learning or actions taken following complaints. We saw action taken included letters of apology, offers of further communication and changes in procedures at the practice.

Staff were able to describe what learning had taken place following any complaint. Complaints were discussed as they arose at the GPs daily meeting and as a standing agenda item at the significant event meetings held every three months.

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 GPs described themselves as a new team with the introduction of new GP, practice nurse and practice manager. Patients said the staff that had left had been popular but the new staff were popular, had settled in well and described the change as smooth. Despite the staff changes the practice had a clear vision for development. The team knew their shortfalls and had strategies in place to address these.. The GPs explained plans for the future and saw the planned health and social care hub as part of the service for their patients.

GPs and other members of staff talked of future plans, succession planning and changes in the business and had kept records of these discussions.

Governance Arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a named partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal. Any clinical or non clinical issues were discussed amongst staff as they arose. For example, incidents were often addressed immediately and communicated through a process of face to face discussions and email. These issues were then followed up more formally at the three monthly significant event meetings. Staff explained these meetings were supportive, well structured and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF scores for Moretonhampstead health centre were above the national average in 13 of the 18 indicator groups we looked at. The practice were able to explain what action (if any) had been taken for the remaining five groups where the score was below average, for example one indicator was not reached because they did not have a patient registered with that condition.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. In addition to the incentive led audits there was a real sense that GPs wanted to perform audits to improve the service for patients and not just for their revalidation or QOF scores. These examples included medication audits, audits on complications following minor surgery. Audits were thorough and followed a complete audit cycle.

Leadership, openness and transparency

There had been recent changes to the leadership team of a new GP and practice manager. Staff said the transition had been smooth and described the new practice manager as a breath of fresh air. The remaining staff group were stable with many staff having worked at the practice for many years.

Nursing and administration staff spoke positively about the communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

GPs said there was support for each other was good. The GPs all worked part time hours but made sure they met on a daily basis to support one another and discuss any concerns they had.

Staff said that because the practice was small, communication was effective. Staff said communication with part time colleagues was done through face to face meetings, email and more formally though meetings and formal staff appraisal.

All staff said they felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

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

Patient feedback was valued by the practice. This was demonstrated by the recent change in length of appointments following patient feedback.

Are services well-led?

Good

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

The practice had a patient participation group (PPG). The PPG representatives who came to the inspection said the practice manager and GPs were keen to encourage patient feedback and involvement. The PPG said they were regularly consulted about various issues and had been able to influence this decision and suggest additional ideas. For example the PPG had been consulted regarding the planned introduction of health and social care hub.

The PPG was advertised on the practice website along with information on how patients could offer feedback.

Management lead through learning & improvement

There was a culture shared amongst staff at the practice of wanting to learn and develop themselves and the business.

A standardised, formal, systematic process was followed to ensure that learning and improvement took place when events occurred or new information was provided. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

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.