Ampleforth Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Ampleforth Surgery on 3 November 2014. We inspected the main surgery at Back Lane, Ampleforth and also visited the branch surgery at Hovingham to look at the dispensary.

We rated the practice overall as good.

Our key findings were as follows:

• The practice provided services to a large geographical and rural area, the services had been designed to meet the needs of the local population.

• Feedback from patients was overwhelmingly positive, they told us staff treated them with respect and kindness.

• Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.

We saw several areas of good practice including:

• A patient centred approach to delivering care and treatment. All staff were aware of and sympathetic to, the particular difficulties faced by the local population living in a rural location.

• The practice had developed daily input into a large local boarding school in the area and provided good responsive care.

• The practice actively sought the opinions of staff and patients, working with a well established patient participation group (PPG) to address and improve patient care experience. The practice and PPG had been successful in developing a volunteer car service transporting patients without transport to and from their appointments at the surgery and hospital.

However, there was also an area of practice where the practice needed to make improvements.

The practice must:

• Improve the checking and signing of prescriptions by GPs before medicines are dispensed and

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issued to patients. They must also improve arrangements for checking the expiry dates of medicines to ensure they are safe to use.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Processes were in place to address any identified risks. We identified a concern regarding the supply of some medicines. Repeat prescriptions were not checked and signed by the GP before medicines are dispensed and issued to patients.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs had been identified and planned. However we saw that some training updates were overdue, the practice had identified these and we saw arrangements in place for further training. We saw that staff appraisals were undertaken although some appraisals were overdue. We saw evidence of good multidisciplinary working.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. All of the patients we spoke with said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and access to a named GP. We saw evidence of continuity of care, with urgent appointments available the same day. The practice was well equipped to treat patients and meet their needs. There was an accessible complaints

Summary of findings

process with evidence demonstrating that the practice responded quickly to issues raised. We saw that improvements could be made to formalise the sharing, and reviewing from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision to improve and develop the practice, however this had not been fully documented. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure, with heads of department identified and staff felt supported by management. The practice had a number of policies and procedures to govern activity some of which were in the process of being agreed and developed. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG) who were fully engaged with the practice and local community.

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

Outstanding 

The practice is rated as outstanding for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of services, for example to treat and manage long term conditions and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits. All patients were contacted following discharge from hospital to ensure they were reviewed and any changes to their treatment responded to appropriately. A home delivery service for medication was available. The practice provided regular visiting clinics for the elderly monks and nuns into the local monastery and convent. The patient forum (PPG) were successful in obtaining funding to provide a local transport service for people who required transport assistance to and from appointments to the surgery and hospitals. The rural location of the practice meant that many older people were living in isolated areas with poor access to public transport. The practice worked with the local community to promote good health and improve access to services for older people. Each older patient had a named GP. District Nurses, and Palliative Care Nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated.

People with long term conditions

Good 

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews and recalls to check their health and medication needs were being met. Access to chronic disease clinics was flexible to suit the needs of this population group. The practice also operated opportunistic screening to ensure patients received regular screening. The practice arranged more frequent reviews for those patients whose condition became unstable.

Families, children and young people

Outstanding 

The practice is rated as outstanding for the population group of families, children and young people. The practice have a population well above the national average for young people due to the local college and schools which provide boarding for students. The

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practice provides daily clinics at the college and weekly clinics at the preparatory school. There are robust processes in place for the monitoring of children and young people who had a high number of A&E attendances. Immunisation rates were good for all standard childhood immunisations and staff could identify the reason for any exceptions.

Same day appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, for example those with learning disabilities and was aware of these patients. The practice had carried out annual health checks for people with learning disabilities and patients had received follow-up appointments when required. The staff were aware of how to sign-post vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health. Patients experiencing poor mental health had received an annual physical health check and review of medicines. The practice could access community mental health support services, and there were good links with the primary care

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mental health worker who visited the practice. The staff were familiar with the multi-agency support services available in the local area for patients experiencing poor mental health and were able to sign post patients.

The practice had a system in place to provide a joint visit with the community psychiatric nurse for patients. The practice were proactive in following up patients who failed to attend the practice for treatment and those who failed to attend hospital appointments.

Summary of findings

What people who use the service say

We received 26 completed CQC comment cards from patients and spoke with four patients who were using the service on the day of inspection. We also spoke with four members of the patient participation group (PPG) known as the patient's forum. The patients and members were extremely complimentary about the service. They told us they found the staff to be caring, supportive, and responsive. They told us the staff provided them with a consistently high level of care.

We saw that a patient survey had been completed in the practice in 2013 and a further PPG survey in 2014. The responses to the questionnaire were all positive. The percentage of patients rating their ability to get through to the practice on the phone as very easy was 97.3%, and 86.9 % rated the experience of making the appointment as good to very good. The percentage of patients rating their practice as good or very good was 94% and 100% stated they would recommend their GP surgery. Patients we spoke with commented that they felt supported, listened to by staff and not rushed during their consultation time with the GP or nurse. We saw that the practice website provided further information about the questionnaire and patients comments and suggestions to improve the service.

The practice had established a positive and proactive (PPG). The group held regular meetings and the minutes of these meetings were made available to patients and staff. The PPG had been responsible for a range of initiatives and improvements. An example of these were improved patient parking, handrails outside the building and the provision of raised chairs in the practice waiting area for those people with mobility problems.

We found that the practice valued the views of patients and saw that following feedback from surveys and the patient participation group, changes were made in the practice. We saw that the practice also produced information detailing how they had responded to comments and suggestions received.

Areas for improvement

Action the service MUST take to improve

Prescriptions must be checked and signed by GPs before medicines are dispensed and issued to patients.

The expiry dates of medicines should be checked to ensure they are safe to use.

Action the service SHOULD take to improve

Emergency equipment should be regularly checked

Ampleforth Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Ampleforth Surgery

The Ampleforth practice is situated in Ampleforth village, and provides primary medical care services, including access to GPs, minor surgery, family planning, and ante and post natal care, to patients living in Ampleforth, Hovingham and the surrounding villages. The practice provides services to 4000 patients of all ages and is set within a rural community. There is a branch surgery at Hovingham. We visited the main surgery and branch surgery dispensary as part of the inspection.

The practice also provides a daily clinic at the local boarding school/ college. The practice has a large number of young people who are boarders at the college and preparatory school this means the practice population of children up to the age of eighteen years is above the national average.

The practice provides a placement for medical students as part of their undergraduate medical training.

The Ampleforth practice is located in a single storey building and has a number of parking spaces on site, including spaces near the main entrance for those patient's with mobility problems. There are disabled toilets and baby changing facilities available.

The practice does not provide out of hours services for their patients. When the practice is closed patients access 111 and for medical emergencies they contact 999. Information for patients requiring urgent medical attention out of hours is available in the waiting area and on the practice website.

The practice has three GP partners, two female and one male. They also employ a salaried GP, an advanced nurse practitioner and two practices nurses.

The surgery is open 8.30 am - 6.00 pm Monday to Friday, with extended hours on a Monday and Wednesday evening. On the first and third Saturday in the month the practice is open between 8 am and 11 am. The practice provides pre bookable and same day appointments throughout the week. Patients can book appointments face to face, by the telephone or online. The practice treats patients of all ages and provides a range of medical services.

Why we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

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 patient'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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 3 November 2014.

During our visit we spoke with a range of staff including two GPs, an advanced nurse practitioner, the practice manager, four dispensary staff, and three administration staff. We also spoke with four patients and four members of the PPG registered with the practice. We observed staff interactions in the reception area. We also reviewed 26 CQC comment cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, and national patient safety alerts, as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The staff told us that they were kept informed and alerted about incidents and concerns within the practice. We reviewed minutes of meetings and saw evidence that these were discussed. This showed the practice had managed and maintained safety in the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and these were made available to us. At the monthly meetings we saw a review of actions relating to risk management, compliments and complaints. We were told by one clinician that there were standing items on the agenda each month but no detailed process for addressing these items had been developed. The example provided was that complaints were discussed but not always recorded at the monthly clinical meeting. We saw evidence that internal investigations were conducted when any incidents occurred and staff confirmed that investigations were undertaken and changes made to prevent them happening again.

The practice had recently developed the role of head of department for each area in the practice areas to improve communication and identified areas of responsibilities. Examples of these were nursing, dispensary and reception staff. There were weekly meetings with the practice manager and head of department where any concerns were briefed and actions agreed. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff.

We reviewed nine significant event audits (SEAs) undertaken in 2014 and saw records were completed. We saw that the practice used a template to record these. The information recorded included the department and staff involved in reviewing the SEA. The meeting date of when the SEAs were discussed was not always recorded. We also saw that the named people responsible for reviewing any actions developed following review were not recorded. This meant it was difficult to establish if all actions had been successful in preventing further occurrences. We saw in one incident the answer machine had not been switched on when the practice had been closed. Following this the heads of department had introduced check lists for staff to follow at the beginning and end of each shift.

National patient safety alerts were disseminated by the internet to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. We saw evidence that alerts were discussed at the staff meetings. This ensured all were aware and what action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. We also saw that staff had undertaken further training. For example one of the GPs had completed a course which would assist them in recognising the signs of grooming of children and vulnerable adults. Staff confirmed they received training and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had a dedicated GP appointed as the lead in the safeguarding of vulnerable adults and children. We were unable to speak with the lead on the day of inspection. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There were systems to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

A chaperone policy was in place. We saw that there was a poster in the reception area however it was not placed to ensure all patients using the waiting room would be aware

of this. Chaperone training had been undertaken by all nursing staff. This duty was usually undertaken by the nursing staff in the practice. When clinical staff visited the boarding schools chaperones were provided by the college and school matron.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. The practice was able to access patient's records when visiting one of the boarding schools by having access to the practice electronic system. The other school did not have electronic access and notes needed to be transported.

The practice was able to identify families, children, and young people living at risk or in disadvantaged circumstances, and looked after children (under care of Local Authority). National data showed the practice had a low level of deprivation in the area. The health visitor and clinical staff confirmed they were able to identify and follow up children, young people and families.

There were systems in place for identifying children and young people with a high number of A&E attendances. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently fail to attend appointments for childhood immunisations were followed up and discussed with the parents to understand the circumstances and reasons for this.

The practice had processes in place to identify vulnerable patients, those with long term conditions, older people and regularly the review patients' conditions and medication. There were processes to ensure requests for repeat prescribing were monitored by the GP's. The staff demonstrated a good knowledge of their practice population particularly frequent users of the service.

Medicines management

Arrangements for managing medicines were checked at the main surgery and the branch surgery. Medicines were dispensed for patients who did not live near a pharmacy. Staff told us that people who were eligible had the choice of having their medicines dispensed at the surgery or their local pharmacy.

The practice had a safe system for reviewing hospital discharge and clinic letters. Where changes to medicines were recommended or made, these were highlighted promptly to GPs who made the necessary changes to patients' records.

The arrangements for the review of medicines for patients with long term conditions were checked. Regular medicines reviews are necessary to make sure that patients' medicines were up to date, relevant and safe. Staff said that the GPs and practice nurse were responsible for these reviews. The practice were co-ordinating reviews so that patients had one appointment to review all long term conditions. The practice nurse carried out reviews in the homes of people who could not attend the surgery.

There was no system in place to ensure that GPs checked and signed repeat prescriptions before the medicines were dispensed and issued to patients. Overall this meant that patients did not receive medicines safely because GPs did not have the opportunity to do a clinical check before they were dispensed.

Arrangements for managing medicines were checked at the surgery. Medicines were dispensed for patients who did not live near a pharmacy and this was appropriately managed. Staff showed us the standard operating procedures for managing medicines (these are written instructions about how to safely dispense medicines) and told us that these were currently being reviewed.

We observed medicines being dispensed and saw arrangements were in place to minimise dispensing errors. Medicine supplied to patients in error were recorded and reviewed to reduce the risk of errors being repeated.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of directions and evidence that staff had received appropriate training to administer vaccines.

Staff told us that there were systems in place for monitoring the expiry dates of medicines. However we found out of date medicines in the emergency bag at the branch surgery. Records showed fridge temperature checks were carried out on the vaccine fridge which ensured this

medication was stored at the appropriate temperature. However no records were kept of room temperatures in the dispensaries to confirm that medicines were being stored at the correct temperatures.

We saw a system in place for managing national alerts about medicines such as safety issues. Records showed that the alerts were distributed by the medicines manager to dispensers who implemented the required actions as necessary to protect people from harm.

Cleanliness and infection control

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

The practice had a lead person for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The staff we spoke with were aware of the importance of infection control. All staff received training about infection control specific to their role and thereafter annual updates. We saw evidence the lead had carried out audits and that actions were identified. The lead person had recently audited hand washing techniques of a nurse as part of their ongoing monitor of infection control and prevention (ICP). The outcome of the IPC monitoring was discussed at the heads of service and practice meetings.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, and aprons were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

The staff were able to describe how they would deal with a spillage of body fluid and needle stick injury. Hand washing sinks with liquid soap, hand gel and hand towel dispensers were available throughout the practice for example toilets, treatment and consulting rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and we saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer. The staff were aware of the importance of reporting any concerns about equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to follow when recruiting clinical and non-clinical staff. We looked at the recruitment records for four members of staff. Three staff were employed by the practice following registration with CQC. The recruitment records we looked at contained evidence that appropriate recruitment checks had been undertaken for three members of staff prior to employment. For example, proof of identification, references, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). In one staff files we did not find details of recruitment checks other than professional registration and DBS checks in place. We spoke with the member of staff who had commenced employment following registration of the practice with the CQC. They told us that they had been invited to apply for the post, interviewed but were unsure if any records of their recruitment process had been taken.

We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. The practice manager who had recently commenced this role told us they were currently reviewing future staffing levels. As part of the process they had identified busy times in the practice where more staff were required. An example of this was Mondays, Fridays and following bank holidays.

Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

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

of the building, the environment, medicines management and equipment. The staff received health and safety training. The practice were currently reviewing and updating the health and safety policy.

We saw that any risks were discussed at the regular meetings team meetings. For example we saw that privacy and confidentiality had been identified as a risk in the Ampleforth practice. The practice had developed plans to erect a partial wall between the reception hatch and the waiting area. The access to the building had also been identified as a potential risk and a hand rail had been positioned from the car park to the entrance.

We saw that staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies. For example the nurses described how they increased the frequency of reviews for patients where their long term condition became unstable or deteriorating.

We saw that for all patients with long term health conditions there were emergency processes in place to deal with their changing needs. Staff gave us examples of referrals to secondary care made for patients that had a sudden deterioration in health.

There were emergency processes in place for identifying acutely ill children and young people, and staff gave us examples of referrals and responses made. The practice had appropriate equipment in place to deal with medical emergencies in these patient groups.

The staff provided examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice told us they have good links with the primary care link worker. The community mental health worker visits the practice weekly.

The practice monitored repeat prescribing for people receiving medication for mental health needs and this was scheduled as part of their annual review.

Arrangements to deal with emergencies and major incidents

The practice arrangements to manage emergencies were not robust. We saw records showing that not all staff had received training in basic life support or undergone a timely update. The practice manager showed us evidence that this had been identified by the practice and training arranged in January 2015.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We saw that the practice had only a small oxygen cylinder without a gauge to establish how much oxygen there is in the cylinder and no back up supply. The practice is situating in a rural area some distance from hospitals and emergency services. All staff we spoke with knew the location of this equipment.

We saw that checks on emergency equipment were scheduled on a monthly basis. However we saw that this had not always occurred. We found a packet of defibrillator pads in one emergency pack out of date since January 2014. The staff were aware of this and had ordered more supplies. Staff had been briefed and knew to use the other defibrillator pack. However robust monitoring of these checks would have identified the out of date equipment immediately.

Emergency medicines were available and all staff knew of their location. Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice was located in a rural area and may be required at times to deal with a range of emergencies before a paramedic was able to attend. Processes were also in place to check emergency medicines were within their expiry date and suitable for use however we found some medicines at the branch surgery were out of date.

We did not find a business continuity or disaster recovery plan in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks would include power failure, adverse weather, unplanned sickness and access to the building. The practice were able to identify how they may deal with a situation but did not have written guidance which would include telephone numbers. We saw that the practice manager and team were currently working towards developing a robust up to date plan. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

Requires improvement

Are services safe?

A fire risk assessment had been undertaken that included actions required in maintaining fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of what action to take in the event of an epidemic, pandemic and major incident mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with ensured that each patient was given support to achieve the best health outcome for them in line with NICE guidelines. In addition to the practice software system, the practice recently purchased an information management system which will assist them in accessing, improving and storing information. Staff told us they had been undergoing training to enable them to use the system effectively.

The GPs, nurse practitioner and nurses told us they led in specialist clinical areas such as diabetes, heart disease and respiratory conditions. We saw that the clinical staff held expertise in the management of different long term conditions. They told us they provided support to each other in the management of patients and discussed new best practice guidance. We found the staff we spoke with knowledgeable. Three GPs had attended a GP update course recently and following this they had shared their learning at the clinic meetings with colleagues. The advanced nurse practitioner recently completed training in this role. The nurse told us currently she was undertaking a master's degree as part of the nurse practitioners course and continually shared learning with colleagues.

We saw evidence that the practice's performance for prescribing was regularly reviewed and this is comparable with the CCG. We saw the practice had a dedicated GP lead for medicines and the dispensary. We saw that the GP was also the CCG prescribing lead. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme. This rewarded practices for providing high quality services to patients from their dispensary.

The practice identified patients with complex needs who had or required multidisciplinary care plans and these were documented in their case notes. We saw that these had been discussed at the practice and multi-disciplinary meetings. The advanced nurse practitioner had completed care plans for these patients in their own home; we were told patients kept a copy of the plans.

We saw a process in place to review patients recently discharged from hospital and to ensure medication changes were also reviewed. The staff told us that they found delays in receiving discharge information from one hospital in their area. We were told the practice had addressed this with the hospital to improve the process and were continually monitoring this. We saw the practice continually reviewed and monitored patient's hospital admissions as part of a contract Directed Enhanced Services (DES). We saw evidence that these were discussed in the practice.

National data showed the practice was in line with referral rates to secondary and other community care service. All GPs we spoke with used national standards for the referral to secondary care and patients with suspected cancers were referred and seen within two weeks. We saw evidence that regular review of elective and urgent referrals were undertaken by the practice. The practice had a low level of patients attending Accident and Emergency (A&E). This was thought to be due to the geographical location being some distance from the local A&E departments.

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.

The practice did not use the Choose and Book system to refer patients to secondary care and this was currently being reviewed and a new system planned. The referrals were discussed with patients and letter drafted and sent to the appropriate service. A copy of the referral letter was always given to the patient. The practice started giving patients a copy of the letter 10 years ago as this ensured they were aware of the reason for referral, and evidence of the referral being sent. The patients we spoke with were positive about the process for referral and we saw no evidence of delays. The process had not been monitored or audited by the practice to identify any delays.

Management, monitoring and improving outcomes for people

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

Good

Are services effective?

(for example, treatment is effective)

child protection, alerts and medicines management. The information staff collected was collated by the practice management team and used to support the practice to carry out clinical audits and reviews.

The practice showed us three clinical audits that had been undertaken in 2013/14. Multiple cycles of these audits had been completed. Examples of these audits were consent for minor surgery, cost effective prescribing of the Combined Oral Contraceptive Pill and the prescribing of a specific medicine. We were shown another audit of chronic obstructive airways disease (COPD) that had been completed by an external company. The key data recorded indicated improvements in management of COPD. The practice had added no narrative to establish how this audit would be used and reviewed to improve patients care.

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). In discussions with clinicians we were aware of previous audits undertaken in the practice and that clinicians were planning future audits. QOF is a national performance measurement tool. The practice also used the information they collected from the QOF and their performance against national screening programmes to monitor outcomes for patients. This practice was performing within the national and local average.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. We were shown evidence to confirm that following the receipt of an alert the GPs and medicines optimising manager reviewed the use of the medicine in question. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, dispensing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attending mandatory courses such as health and safety and infection control. We saw the practice had identified any overdue training and we saw evidence that training had been booked, for example basic life support. We saw a good skill mix amongst the clinical staff with doctors specialising in different areas, for example mental health, women's health, contraception and hypertension.

The role of advanced nurse practitioner was new to the practice. The clinicians were exploring how they could use the role effectively within the practice. The practice also provided a placement opportunity for medical students. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. In the records we looked at we saw that two appraisals were overdue. We discussed this with staff and saw that plans were in place to address these. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses required for their professional development. We spoke with the practice manager who told us the practice would be joining a federation where one of the key objectives was the improvement and access to training for all staff across the GP federation group. A GP federation is when a group of GP practices come together for the purpose of developing patient services in a collaborative manner.

The clinical staff had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and smoking cessation. The practices nurses were seeing patients with long-term conditions such as asthma; COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. The practice used a template for communication on their electronic systems. Examples of this were communications with the out of hour's service regarding patients advanced decisions. Letters from the local hospital including discharge summaries, blood results, X ray results, and the 111 services were received both electronically and by post.

The practice outlined the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The practice manager explained that they had highlighted the need to improve upon this process. However we saw no documented risks relating to this process. All staff we spoke with understood their roles and felt the system worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We were told the practice were continually reviewing unplanned admissions to hospital and discharges.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients e.g. those with end of life care. These meetings were attended by district nurses, health visitors, social workers, and palliative care nurses, and decisions about care planning were documented in a shared care record. We saw that at the first part of the meeting they were joined by local providers of care in the locality were care was being provided into people's homes. This meant they were able to discuss any concerns and brief clinicians on patients they visited. Staff felt this system worked well and it was evident that there was a good working relationship with staff from other professions.

Information sharing

The practice used electronic systems to communicate with other providers and letters. The practice did not currently use electronic systems for making referrals. They established current waiting times, type a letter with the patient and task the administrative staff that cut and paste the letter into the correct format and forward the letter appropriately. The patient is given a copy of the letter to keep as a reference to the referrals being made. We were told there were no current checks or audits made of this system however we saw no evidence of delay. The practice told us there were plans in place with the CCG to introduce a new electronic system to replace this system. We saw that all two week referrals were faxed to the hospital.

The practice had electronic systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw MCA training was booked for April 2015. We did not find a policy for MCA in place. We discussed this with the practice manager who was reviewing all policies and assured us they will address this.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, minor surgery and when verbal and written consent was required. The practice also undertook audits to identify any issues relating to the process and actions to improve consent. We looked at this audit and saw that following the first cycle and actions the second cycle showed an improvement.

Health promotion and prevention

All new patients registering with the practice were offered a health check with the practice nurse or nurse practitioner.

Good

Are services effective?

(for example, treatment is effective)

The GPs were then informed of all health concerns detected and these were followed-up in a timely manner. Treatments were also checked to ensure that they followed evidence based practice. The GPs and nursing staff were proactive in offering opportunistic screening for example, by offering cervical screening and promoting healthy life styles. We did not see any information on the practice website about new patients registering with the practice.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all of these patients were offered an annual physical health check.

The practice had also identified the smoking status of patients over the age of 16 and actively offered a smoking cessation service to these patients. Similar mechanisms for identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was within the national and local CCG average. There was a process to remind patients who did not attend for cervical smears. Patients who did not attend were followed up. We saw that the practice information detailed which staff were available for example the practice nurses. Mechanisms were in place for following up patients who did not attend for screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for immunisations was good. The practice had reviewed performance and where immunisation had not been done had investigated the reason. This provided the practice with assurance that missed immunisations were not linked to safeguarding concerns.

The practice also offered NHS Health Checks to all its patients aged 40-75. The staff told us patients who had risk factors for disease identified at the health check were followed-up and were scheduled for further investigations.

We found that for areas such as smoking cessation, weight management, and alcohol and drug abuse were responded to in the practice on a need basis. We saw staff held areas of expertise had undergone further training in areas such as smoking cessation and drug abuse. The practice newsletter provided a source of information about a range of health promotion initiatives. Examples of these were flu campaigns, healthy heart checks, shingles vaccines and stopping alcohol or smoking in Octobers. The practice offered health checks to patients to screen for undiagnosed conditions such as high blood pressure, diabetes, heart disease, heart failure and COPD. These were promoted on the practice newsletter however there wasn't a dedicated health promotion link or page on the practice web site.

The practice had a register of patients who were identified as being at high risk of admission and at the End of Life. We saw that clinical staff had a good level of knowledge and expertise in this area. The practice had developed up to date care plans which they share with other providers. We saw evidence of a good working relationship and joint working with other providers for example the community matron and local authority. People over 75 had a named GP to promote continuity of care and a review of medicines for polypharmacy. The practice had processes in place to review all unscheduled admissions to acute services.

The practice had a register of all patients suffering long term conditions(LTC) and ensured these patients had structured annual reviews for various LTCs such as Diabetes, COPD (chronic obstructive airways disease) and Heart failure. There were identified leads with expertise in the different conditions and this ensured patients received evidence based treatment. The practice QOF scores showed that the practice were preforming well for the management of all LTCs and were above the local and national average. We saw that there were good working relationships with the multidisciplinary team and regular meetings to discuss patient care. There were comprehensive screening and vaccination programmes which were managed effectively to support children and young people. We saw that were there were concerns with patients conditions more frequent reviews were established

The practice provided a range of services for patients to consult with the GPs and nurses, including on-line booking, repeat prescription requests and telephone consultations. Staff had a programme in place to make sure no patient missed their regular reviews for their condition, such as diabetes, respiratory and cardiovascular problems and offered text reminders for appointments. We saw that there was a good take up of healthy heart checks, cervical smears and blood pressure checks.

Good

Are services effective?

(for example, treatment is effective)

The practice was aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. We found that all of the staff had a very good understanding of what support services were available within their catchment area. Staff were knowledgeable and proactive when safeguarding vulnerable adults. They had access to the practice policy and procedures and discussed vulnerable patients at the clinical meetings and with the named clinical lead.

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medicines review.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, and further surveys undertaken in the practice. There were links on the practice web site to the practice questionnaire. The Patient Participation Group PPG also known as the patients reference group were also involved in developing a questionnaire. This questionnaire has been developed by Ampleforth and Hovingham patient reference group to highlight what the practice is doing well and identify what needs attention. The results were then published in the practice newsletter. We saw that patients could access these on line and in the surgery. They asked a range of questions such as, are you concerned about a lack of privacy when you are talking to the receptionists, can you read staff name badges, do staff introduce themselves, can you access appointments and is the telephone answered promptly.

We saw that the results of questionaries' also included patient's positive and negative comments received during the process. We saw that action had been taken to address people's comments and use their comments to improve the service. The practice addressed the privacy at reception by arranging for a wall to be erected between the reception desk and waiting room to provide privacy. Staff all introduce themselves now on the telephone, wear name badges, and parking issues had been addressed and the improvement monitored. When we spoke with the PPG they told us that the practice always responded positively to patient's ideas and comments.

We saw form the evidence from the different sources that patients were satisfied with how they were treated and access to services. For example 94% of patients rated their experience as good or very good. 98% of patients rated the practice as being easy to get through to. All patients were positive in recommending their service to family and friends. This demonstrated patient's satisfaction with the service.

We received 26 CQC cards, all were positive about the service experienced. We saw on the NHS Choices web site that three patient's had left reviews and rated the practice as five star. We saw a range of positive comments from patients. We also spoke with four patients on the day of our inspection and four members of the PPG. All told us they were very happy with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff adhering to the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We saw that there were no questions and triaging of patients by the reception staff were difficult questions may be asked. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Patients could also ask to speak with staff in private. We saw in the PPG meeting minutes that they complimented staff on dealing with difficult patients and their calm efficient and friendly approach in dealing with all patients.

We observed staff dealing with all people regardless of circumstances in a friendly, sensitive, sympathetic, and professional manner.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. We saw good patient involvement an example of this had been the recent care planning for vulnerable patients. The patients we spoke with told us they were involved in decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

Good

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

We saw that the practice also delivered a service into the local monastery as well as the school. We saw positive feedback from these that they were happy with the timely response and service the practice delivered.

Staff told us that translation services were available for patients who did not have English as a first language. The staff told us they have very few patients in the area requiring this service.

We saw evidence that the practice had developed personal care plans for patients with complex needs such as some older people or end of life care and a copy had been sent to them. The practice told us that any patient they felt had complex needs were included and care plans developed.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it good in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, we saw that the practice followed up all bereavements in the practice either by telephone or sending a card. We found that there was a good understanding of patients and their circumstances. We saw staff responded compassionately when patients needed help and provided support when required.

There was information in the waiting area sign-posting people to a number of support groups and organisations.

The practice is located in a rural area and some addresses are difficult to find and in remote locations. We saw that on the practice website patients were encouraged if they lived in a remote or difficult to find location, to contact the ambulance service and advise them of their location and the best route to their property. This meant that should a patient require the services of an ambulance in an emergency the ambulance service knew exactly how to reach them.

The administration staff told us the practice had a carers register. However when we spoke with the clinical staff they were not aware or uncertain if a register of carers within the practice was in place. It was unclear how carers were offered support in their role as carers by the practice.

The practice had a high number of young people. The PPG were aware of this large number of young people and were continually trying to engage this group without success.

We saw evidence that the practice works jointly with the health visitor and school nurse to address the needs of children and families in the area.

We saw that people suffering with long term conditions received regular annual reviews and if deemed appropriate they were reviewed more regularly. From the comments we received people told us they felt supported and had good access to services. The staff were aware of co morbidities and depression that may accompany these conditions.

We saw that access to transport for appointments to the surgery and hospital was difficult in the rural area. The PPG with support of the practice had been successful in receiving funding to provide volunteer driver to take patients to and from appointment. This scheme had proved successful and appreciated by patients who may not have transport and were access to public transport was not available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw that one of the practice partners spent one day a week working with the CCG. Staff told us that the GP kept them updated about development and changes. We saw that the GP had explained their role to the PPG to enable them to understand how the practice and CCG worked together to improve care.

We saw that there had been a number of changes in staffing over the last few years. However many of the staff remained the same which promoted good continuity of care and accessibility to appointments with a GP and practice nurses of their choice.

We saw that in response to patient comment the practice offered fifteen minute appointments. The practice also provided longer appointments where needed for example those with complex or multiple long term conditions. Home visits were made to those patients who needed one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. Examples of these were the introduction of a number of high chairs in the waiting area for those patients with mobility difficulties and the offer of text reminders to patients for appointments.

There was a palliative care register in the practice with regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. As a consequence of staff training and expertise in this area the staff had a better understanding of the needs of patients and the skills and knowledge to care for patients. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. There were regular scheduled meetings with community nurses, end of life care and other health providers.

Tackling inequity and promoting equality

The practice had recognised the needs of different patient groups in the planning of services, such as those with a learning disability, travellers and the high proportion of children, and students. The practice were able to identify different patient groups and respond to their needs. The practice actively promoted the services available to patients in the local community and worked collaboratively with the PPG and local village groups.

The practice does not have many patients who require translation service. The staff told us they have access to language translation services should they require this.

The premises at the main surgery and branch surgery had been adapted to meet the needs of people with disabilities accessing the service. The practice had ensured there was a hand rail available from the car park to assist patients following feedback from patients. Patients had also commented on the difficulty in getting a car parking space. Following this comment the practice had ensured staff accessed car parking away from the surgery; ensuring patients had good access to car parking close to the entrance of the surgery.

Access to the service

Ampleforth practice reception and dispensary were open from 8 am until 8pm on a Monday and Wednesday and 8am until 6.30 on Tuesday Thursday and Friday. Appointments with the GP were available from 9am until 7.30pm Monday and Wednesday and from 9 am until 6 pm with a break during the afternoon. Appointment times with the nurse and Health care assistant were also detailed to help patients know when they were available. The practice also opened the first and third Saturday of each month during the morning at the Ampleforth surgery.

The opening times for the practice and dispensary at the Hovingham site were different. However the practice provided access to GPs and nurses during each day at both sites and patients were able to book appointments at either site.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice also provided a daily clinic at Ampleforth college each day and once a week at the preparatory school. Patients from the school were also able to access the practice at the other sites.

The patient information and practice website provided further details of bookable appointments with the GPs, practice nurses, advanced nurse practitioner and health care assistant. The practice provided information to patients to ensure they were able to access urgent medical assistance when the practice was closed.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. We saw that patients in need of urgent treatment were able to make appointments on the same day of contacting the practice.

The Ampleforth and Hoveringham provided patient services on one level. We saw that the waiting area was large enough to accommodate patients with wheelchairs. Accessible toilet facilities were available for all patients attending the practice. There were baby changing and breast feeding facilities available.

The practice offered an online booking system which was available and easy to use. They offered text message reminders for appointments to those patients who had provided their mobile telephone numbers. The PPG undertook a survey asking patients if they were aware of these different services and what they thought of them. This assisted the practice in understanding what patients thought of the service they provided and identified were patient's may have difficulties.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Patients could complete a form about a complaint, provide suggestions and raise concerns.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. We looked at fourteen complaints received during 2014 and found these were satisfactorily handled and dealt with in a timely manner.

The practice reviewed complaints and compliments on a regular basis and discussed these in their practice meetings. Staff confirmed these were discussed during the meetings however they were not always recorded in the minutes of the meetings. This meant there were no records available of the staff discussions and ideas of how the complaint could be addressed or when it would be reviewed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. In the practice newsletter the practice were promoting the friends and family test which details what patients should expect from the practice and what they plan to deliver. We saw also in the PPG annual report information about what plans the practice have for the future and how they have acted upon the suggestions received from patients. We saw that the practice were working to ensure patients were kept informed about the future plans for the development of the service. Examples of this were the planned structural work to the practices.

The staff we spoke with knew and understood the vision and values and what their responsibilities were in relation to these. Examples were the development of the nurse practitioner role and improved confidentiality in reception. We saw that although the vision for the future had been discussed and planned no formal plans were in place. The practice outlined their plans for the future and provided some detail of how they would address these during our visit. We saw that staff regularly came together at a range of formal meetings to discuss practice business, training, future developments and patient's on-going care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via hard copy and the computers within the practice. We saw that the practice manager who recently came into post had a system in place to review and were necessary develop policies. We found that some policies had been reviewed and others were waiting to be approved or reviewed. The practice had recently purchased an electronic system that would assist them in reviewing, monitoring and identifying when staff had accessed the policies. We saw that some policies that had been reviewed were done well examples of these were the safeguarding policies. We looked at these policies and procedures and they were regularly reviewed and were up to date.

The practice held regular monthly meetings with staff and weekly meetings with the heads of department. We saw that they reviewed performance, unplanned hospital admissions and clinically related issues, staffing and concerns. We looked at minutes from meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed they were performing well above the national and local standards. We saw that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example consent for minor surgery, and the prescribing of different medicines. We saw that GPs undertook regular audits and shared the results within the practice to improve care.

The practice had arrangements for identifying, recording and managing risks. The practice did not have a nominated risk manager. All of the staff we spoke with told us they were aware of the importance of reporting risks and concern and would ensure they were actioned immediately. We saw that where risks had been identified the practice had addressed these. An example had been the introduction of an outside handrail from the car park to reception area.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff and identified key roles and responsibilities. We saw the practice web site provided information about key members of staff and their areas of expertise. For example contraception, women and children's health.

Staff in the practice were clear about the roles and responsibilities held by staff. An example of these were safeguarding and infection control. The staff we spoke with were clear about their own roles and responsibilities. Staff told us that felt valued, supported and knew who to go to in the practice with any concerns.

We saw that team meetings were held regularly. Staff told us were happy to raise issues at team meetings and felt included. We saw that the practice held regular multidisciplinary meetings to discuss and plan patient's care. Examples of these were end of life and patients requiring extra support.

Are services well-led?

Good

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

We reviewed a number of policies in the practice. Examples of these were recruitment, sickness and absence policies. Staff we spoke with knew where to find these policies if required and felt confident in speaking with the management team who they told us were supportive.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys; use of a suggestions, complaints and compliments received which they shared with staff. We looked at the results of the annual patient survey and saw the overall patient satisfaction was high with a 100% of patients saying they would recommend the practice to a friend.

The PPG were very active and produced information for patients which outlined how they had responded to concerns and suggestions. The group were well established and had representatives from the various population groups. The group were continually trying to engage younger patients; so far they had been unsuccessful. The group produced an annual report and actively communicated with patients in the local communities.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that two members of staff had received regular appraisals which included a personal development plan. We saw that the other appraisals had been booked and the staff told us they had been given a template to help them prepare for the appraisal. All the staff we spoke with told us the management team were supportive and they had access to the training they required to fulfil their roles and responsibilities.

The practice provided block placements for medical students. There was a named GP lead to support the training and we saw evidence that this was a popular placement for students. This means the practice has an active role in the training of new doctors.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected from the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. There was no system in place to ensure that GPs checked and signed repeat prescriptions before the medicines were dispensed and issued to patients. Overall this meant that patients did not receive medicines safely because GPs did not have the opportunity to do a clinical check before they were dispensed.