Yorkleigh Surgery - CT

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out our inspection on 6 January 2015. We inspected Yorkleigh Surgery as part of our new comprehensive inspection programme.

Overall we found the practice is rated as good. We saw examples of patient centred care provided by a safe, effective, caring, responsive and well led practice. Patients reported high levels of satisfaction with the practice during our inspection and this was reflected in the comment cards we also received.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to medicines within GP bags.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. 100% of patients in the national GP survey had confidence and trust in the last GP they saw or spoke with.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- The practice offered patients access to the 'expert patient programme' which supports patients with chronic illnesses to learn skills to self-manage their illness.
- The practice manager was a registered 'Carers Champion' for approximately 40 carers on the practices register and checked on their wellbeing and support needs.

The areas where the provider must make improvements are:

- Monitor medicines in GPs bags to ensure they are within expiry dates and ensure emergency equipment is discarded appropriately when past its use by date.

In addition the provider should:

- Review the effectiveness of the process for recording medicines, medicine stock checks and the removal of medical equipment which might otherwise be used.
- Ensure learning from complaints and significant events is systematically shared with staff and a clearer chronology of events is kept.
- Ensure minutes of all practice meetings are available to all staff.
- Ensure a record of infection control audits includes actions to be taken and clearer identification of areas that need refurbishing to further enhance the practice.
- Review its appraisal system in regard of training made available to staff.
- Review the process for retaining audits completed by GPs as part of their appraisal process for use as an educational resource for others in the practice.
- Review the process for supporting patients who did not have English as a first language.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Risks to patients were assessed and well managed, with the exception of those relating to medicines within GP bags. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

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needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The majority of patients in this age range had been offered cognition testing where it was felt appropriate. Most patients with a new diagnosis of dementia recorded had a record of calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded. We saw evidence through meeting minutes of multidisciplinary case management meetings having taken place for the most vulnerable patients in this age range. Each patient over 75 years was provided with a named accountable GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice offered patients' access to the Expert Patients Programme (EPP). The EPP is a self-management programme for patients who are living with a chronic (long-term) condition. The aim is to support patients by increasing their confidence, improving their quality of life and helping them manage their condition more effectively. The practice promoted this on their website and in their patient handbook, currently almost 40 patients had signed up to this programme.

Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease and heart failure. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were

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added to the Out of Hours system to share information and patient choice with other service providers. These patients also had access to on the day consultations to ensure their needs were met promptly.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Mother, babies, children and young people were supported by a range of appropriate services and skilled and knowledgeable staff. A safeguarding policy was in place and monthly multidisciplinary meetings with both district nurse for adults and the health visitor for children under school age were provided. There was a system in place for school aged children involving contact from the school nurse and information sharing with the practice. Where concerns were highlighted patients were placed on either the child protection register or the child in need register.

Working age people (including those recently retired and students)

Good

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

Working age patients were usually provided with their choice of appointment time, with routine practice appointments available from 8:00 am until 7:45 pm. Surgeries were also provided over lunchtimes and a phlebotomist was available every day of the week to cover lunch periods for patients to attend for blood tests. Both “book on the day” emergency and pre-bookable phone calls were

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also available throughout the day; the practice aimed to schedule these at mutually convenient times. If there was a lack of suitable appointments both of the practices prescribing nurses sought to fit patients in during their triage clinics to cover the patients' needs.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for patients with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.

Patients in vulnerable circumstances had access to a range of clinics and appointments. A sexual health clinic was provided on Monday afternoons and was both a drop in and bookable service. Health promotions such as breast screening, cytology and smoking cessation clinics were also routinely provided. Carers were encouraged to have annual health checks to ensure they remain well.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Over half the people experiencing poor mental health had received an annual physical health check, all patients had been offered these checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to

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follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training about how to care for patients with mental health needs and dementia.

Patients experiencing poor mental health who are on the practices mental health, learning disabilities, or dementia register were offered annual health checks, over half had taken up this offer. All of the GPs had emergency appointments available each day which were most frequently used for patients who were experiencing a mental health problem. A weekly Mental Health Triage Worker clinic was held at the practice for those patients who may benefit from more specialist care.

Summary of findings

What people who use the service say

We spoke with 16 patients visiting the practice and two members of the patient participation group during our inspection. We received 38 comment cards from patients who visited the practice and saw the results of the most recent patient participation group survey. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice.

All of the comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving good care and treatment, about seeing the same GP at most visits and about being treated with respect and consideration. Comments from carers also spoke positively about the support they received in regard of their caring role as well as being a patient. Comments about the reception team were equally positive.

We heard and saw how most patients found access to the practice and appointments easy and how telephones were answered after a period of waiting. The most recent 2014 GP survey showed 97% of patients found it easy to get through to the practice and 99% of patients found the appointment they were offered was convenient for them.

Some patients also told us they used the practices online booking systems to get appointments. Others told us about GPs calling them back to identify what was the best way to help them or to offer immediate appointments.

Patients told us their privacy and dignity was respected at all times both during consultations and in the reception and waiting areas. They told us they found the reception area was generally private enough for most discussions they needed to make. 95% of patients said they found the receptionists at this practice helpful. Patients told us about GPs supporting them at times of bereavement and providing extra support to carers. A significant number of patients had been attending the practice for over 20 years and told us about how the practice had grown and how they were always treated well. The GP survey showed 90% of patients said the last GP they saw or spoke with was good at giving them enough time and 100% stated they had confidence and trust in the last GP they saw or spoke with.

Patients told us the practice was always kept clean and tidy and recently it was refurbished and improved. Online repeat prescription facilities had been added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. 98% of patients described their overall experience of this practice as good.

Areas for improvement

Action the service MUST take to improve

- Monitor medicines in GPs bags to ensure they are within expiry dates and ensure emergency equipment is discarded appropriately when past its use by date.

Action the service SHOULD take to improve

- Review the effectiveness of the process for recording medicines, medicine stock checks and the removal of medical equipment which might otherwise be used.
- Ensure learning from complaints and significant events is systematically shared with staff and a clearer chronology of events is kept.
- Ensure minutes of all practice meetings are available to all staff.
- Ensure a record of infection control audits includes actions to be taken and clearer identification of areas that need refurbishing to further enhance the practice.
- Review its appraisal system in regard of training made available to staff.

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- Review the process for retaining audits completed by GPs as part of their appraisal process for use as an educational resource for others in the practice.
- Review the process for supporting patients who did not have English as a first language.

Outstanding practice

We saw areas of outstanding practice including:

- The practice offered patients access to the 'expert patient programme' which supports patients with chronic illnesses to learn skills to self-manage their illness.
- The practice manager was a registered 'Carers Champion' for approximately 40 carers on the practices register and checked on their wellbeing and support needs.

Yorkleigh Surgery - CT

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, a practice manager and a second CQC inspector.

Background to Yorkleigh Surgery - CT

Yorkleigh Surgery, 93 St Georges Road, Cheltenham, Gloucestershire. GL50 3ED; is located close to the city centre of Cheltenham. The practice covers a large area in and around Cheltenham including, Prestbury, Up Hatherley, Leckhampton and Charlton Kings.

The practice is part of the Gloucester Clinical Commissioning Group and has approximately 9,000 patients. The area the practice serves has relatively low numbers of patients from different cultural backgrounds. The practice area is in the mid-range for deprivation nationally.

The practice facilities include six consulting rooms and four treatment rooms. Access into the street level of the practice is via three short steps with support provided by hand rails. There is level access via a sloped driveway into the lower floor consulting and treatment area of the practice with a disabled person's parking space at that level. A bell is provided to alert staff if patients require assistance to enter at the lower level. Reception staff are normally aware if a patient who requires assistance is attending the practice. Toilets are accessible with facilities for patients with disabilities and a baby changing area. A small amount of parking is available at the front of the practice with other parking available close by. There are a range of administrative and staff areas including meeting rooms within the practice, most of which are on the first floor.

There are two female and two male GP partners in the practice. Additionally there is locum GP working in the practice. In addition there are two prescribing nurses, two nurses and one health care assistant; a phlebotomist visits the practice to carry out blood tests as required. The practice also employs a small team of reception and administrative staff including a finance manager and office and IT manager. These teams are supported by a practice manager.

The practice has a General Medical Services (GMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This Gloucestershire wide service is provided by Harmoni and patients are directed to this service by the practice during out of hours.

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

Detailed findings

The information about the practice (Public Health England 2012/13) showed the patient demographic profile for the population was approximately:

- Older patients over 65 years 16.6% (over 75s 7.8%)
- Children and young patients under 18 years 18% (under 5s 5.1%)
- Working age population 66%

The population profile for the practice broadly matched the national average patient age profile.

Why we carried out this inspection

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

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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 6 January 2015.

We talked with the majority of staff employed in the practice. This included four GPs, a prescribing nurse, a practice nurse, the health care assistant, the practice manager and five administrative and reception staff. We spoke with 16 patients visiting the practice during our inspection, two members of the patient participation group and received comment cards from a further 38 patients.

Requires improvement

Are services safe?

Our findings

Safe track record

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a letter of complaint was received from a patient, it was identified as a possible significant event. The letter was passed to the management team and the complaint was discussed under the practices significant events processes

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

There were formal arrangements in place for obtaining patient feedback about safety. The practice had carried out an in-practice patient survey and had an active Patient Participation Group (PPG). The practice manager told us that any concerns raised would be used to inform action taken to improve patient safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events was a standing item on the practice meeting agenda and a meeting was held at the time of the annual return to the Clinical Commissioning Group to review the significant events. Complaints and significant events were also reviewed at the time they occurred during partners meetings. There was evidence that the practice had learned from these events however, evidence of how this learning was systematically shared with relevant staff was limited. Staff, including receptionists, administrators and nursing staff told us they knew how to raise an issue for consideration and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the process they used to manage and monitor incidents. We tracked five incidents and saw records were completed, scheduled for discussion and actioned in a timely way. We saw evidence of action taken as a result. For example, where a patient had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. However, the actions recorded on significant event forms lacked detail for example, “patient diagnosed and referred” and did not show a clear chronology from the incident through to sharing learning from the event. The lack of detail could make it time consuming to check retrospectively what the actions were completed appropriately.

National patient safety alerts were disseminated by the partners and the practice manager to practice staff. Staff we spoke with gave examples of recent alerts that were relevant to the care they were responsible for. They also told us and we saw from meeting minutes provided to us that alerts were discussed in management and partner and nurses meetings. This ensured all staff were made aware of those relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the

necessary training to enable them to fulfil this role for example, level three for children and a similar level of learning for vulnerable adults. All staff we spoke with were aware who these lead staff were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments for example, children subject to child protection plans and vulnerable adults on the palliative care list. Monthly meetings were also held to discuss all patients near to the end of their life, those diagnosed with cancer and vulnerable patients, and children where there were welfare or child protection concerns. These meetings were held with members of the district nursing team and health visitors. However, whilst these meetings were minuted and held on the practices computer system the minutes were not automatically shared with other staff unless they were directly involved in the incident.

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

The practice had a system for identifying children and young people with a high number of accident and emergency (A&E) attendances. Patient A&E attendances were continuously monitored and where frequent attendances were identified patients were invited to an appointment to review their healthcare needs. The partner with lead responsibility for safeguarding attended child protection case conferences and reviews and serious case reviews where appropriate. These patients were routinely discussed at multidisciplinary team meetings.

Older patients, families, children and young people and vulnerable patients who were on the practices list of most vulnerable patients were also discussed at weekly multidisciplinary team meetings. The practice had a system in place which ensured patients including those diagnosed with co-morbidities (two or more diseases existing at the same time in the body) or took multiple medicines were reviewed. These reviews took place when the patients' condition changed. We heard how all GPs were aware of the patients on the practices list of most vulnerable patients. All care plans for patients on this list were reviewed in line with changes in their conditions or circumstances. There were alerts placed on the patient record system to remind GPs and nurses about the vulnerabilities of these patients.

Medicines management

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

Processes were not in place to record the checks made of medicines to ensure they were within their expiry date and suitable for use. A stock control system was not in place to ensure medicines could be accounted for. However, all the medicines we checked were within their expiry dates and through a lengthy process staff could account for medicines used and state the amount of stock that should remain. Expired and unwanted medicines were disposed of in line with waste regulations. The GPs bags we checked were disorganised and cluttered and had not been routinely checked by the practice as part of the regular medicines checks for some time. We found out of date medicine ampoules, needles and blood glucose monitoring sticks. Some medicines were more than six years out of date. These medicines and equipment were highlighted to the GPs so they could be removed and replaced.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics (medications that cause sleep) and sedatives and anti-psychotic (medicines that are mainly used to treat schizophrenia or mania caused by bipolar disorder) prescribing within the practice. For example, patients were invited into the practice to have their medicines reviewed following guidance about the strength of medicines patients should receive.

Requires improvement

Are services safe?

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of patient group and patient specific directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. There was a clear audit trail for the authorisation and review of repeat prescriptions. Alerts were raised when the GP was required to review the medicines or if the patient requested medicines early. Any changes to the patient's medicines were flagged on the computer system

The practice had established an electronic prescription service for patients to pick up their dispensed prescriptions at a number of pharmacy locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be generally clean and tidy however carpets in a consulting room appeared worn and discoloured. We also observed damp areas on the walls of two consulting rooms. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a member of staff with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead person had carried out audits for the previous year and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during intimate patient examinations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. However some aspects of the practices systems for checking infection control were less robust. We noted three armchairs had damaged armrest surfaces which could harbour infection and carpets in the triage room appeared stained. Three waste bins lacked lids and a further bin was damaged and required opening by hand.

Notices about hand hygiene techniques were displayed in most staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hot water was supplied by small water heaters in most locations, warning signs indicated the likelihood of very hot water. The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

We saw sharp bins were available along with bins for the disposal of household and clinical waste which had lids and foot operated pedals. There was a contract in place for the removal of all household, clinical and sharps waste and we saw that waste was removed by an approved contractor. We saw equipment used in the practice was clean.

Equipment

Requires improvement

Are services safe?

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

Staffing and recruitment

There was little turnover of staff and sickness absence was low. Staff told us this promoted consistency and the practice felt they had a committed team.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. We saw that checks had been carried out such as proof of identification, references and qualifications. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. A risk assessment was in place for those staff not requiring DBS checks.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We were shown records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Administration staff explained they all had a deputy to ensure their work was covered when they were absent; they told us that annual leave was managed by the practice manager to ensure enough staff were on duty.

One of the GP partners explained to us that there was a protocol for GP annual leave and if they knew that there was a forthcoming shortfall in GP cover they would arrange for extra sessions to be worked by existing GPs as far as possible. There were arrangements with locum GPs who had provided cover when necessary to the practice for some time. The GP partner we spoke with and staff were very aware of ensuring there was appropriate cover to provide a service to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, emergency processes were in place for identifying acutely ill children and young people and patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. Emergency processes were in place for acute pregnancy complications and staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check

whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. However, there was a large amount of medical equipment available. There was in date equipment for all required equipment and in all sizes, but amongst the in date equipment there were some out of date items for example, syringes, swabs and paediatric face masks. There was a risk that these might mistakenly be used in an emergency situation and could be less effective in supporting patients. We raised this with the nurse on duty. They removed all out of date equipment and rechecked all other equipment to check they were in date.

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 an electrician to contact if the lighting failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. There was an evacuation procedure displayed on the walls within the practice which set out who the 'emergency controller' was in case of evacuation and their role. The procedure also listed which member of staff was a designated fire warden.

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 this, for example, the loss of a GP and the mitigating actions that had been put in place to manage this.

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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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of partner meetings and separate nurses meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure that each patient received support to achieve the best health outcome for them. However the staff we spoke with told us this information was not jointly discussed to ensure consistency of understanding. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they had lead responsibility in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss their practice to ensure effective patient treatment and support. Our review of the clinical meeting minutes confirmed that this happened.

All patient contact and correspondence was recorded onto patient journals for completeness and if it was felt any information should be shared with another professional or added to the Out of Hour's system this was completed to ensure information that would enhance the patients care was shared with relevant service.

We reviewed data from the local Clinical Commissioning Group of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with Atrial Fibrillation which showed all were receiving appropriate treatment and regular reviews. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed immediately or within two weeks by their GP according to the patients' needs.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients for example, patients with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. Data from 2013 to 2014 the quality and outcomes framework (QOF) returns showed 96% of patients with a cancer diagnosed within the preceding 15 months, had a review within 3 months of their cancer diagnosis. This figure was higher than the majority of other practices in the CCG area. (The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

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

Management, monitoring and improving outcomes for people

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

The practice showed us seven clinical audits that had been undertaken in the last two years. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit about records received and summarised to ensure patient records reflected the latest information. The audit showed improvement in the way

information was made available promptly. Other examples included audits to confirm that the GPs who saw patients with a diagnosis of osteoporosis were doing so in line with National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding Atrial Fibrillation. Following the audit, the GPs carried out treatment reviews for patients who were identified with Atrial Fibrillation and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 87% of patients with diabetes had their cholesterol measured within the preceding 12 months and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and partner meetings to assess the performance of clinical staff. The GPs we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. GPs spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical GPs should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 that the latest prescribing guidance was being used. The electronic patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients. The practice showed us evidence that every patient aged 75 years or over had a named GP. This process also included patients on their most at risk register who may be under 75 years of age. Unplanned admission discharge summaries were passed to the practice manager to action and ensure any recommendations were followed up.

Effective staffing

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with nursing staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the practice nurses confirmed to us that they were undertaking update training in paediatrics later in the month and were also attending a nurse prescribing update in February. We saw from staff

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training records that staff had undertaken training relevant to their roles such as conflict resolution, a certificate in business studies, deprivation of liberty safeguards, basic life support and Health & safety.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, nurses giving family planning advice had received training in emergency contraception. Those with extended roles involving 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.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and general logistical information about how the practice operated. We spoke with a member of staff currently in the process of completing their induction. They told us that they had been well supported to undertake the duties required of their role and that that appropriate guidance and advice had been given to them.

The administrative and support staff had clearly defined roles, additionally they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the protocol for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice worked closely with other health and social care providers, to co-ordinate care and meet patients' needs. We saw multidisciplinary team meetings were held to discuss those patients at high risk of unplanned hospital admissions or those living in vulnerable circumstances. The multidisciplinary team included community nurses, social work and health visitor teams.

We found appropriate and effective end-of-life care arrangements were in place. The practice maintained a palliative and pre-palliative care register which was updated as necessary, and the patients on these registers were usually visited at home. We saw procedures were in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider.

Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the patient's referring GP and the duty doctor. We saw the practice computer system was used effectively to log and progress any necessary actions.

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

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication

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with accident and emergency (A&E). The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (Vision) to coordinate, document and manage patients' care. All staff were fully trained and received on-going support 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. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. We saw evidence of how GPs applied this policy when supporting patients. They did this by involving the local authority's mental capacity act assessor as well as the social work team and family carers. The patient record showed these involvements as well as the NICE guidelines the multidisciplinary team followed. Learning from this occurrence was later discussed at a subsequent partners meeting.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw how all care plans had been reviewed in last year for these vulnerable patients. When interviewed, GPs gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. A practice nurse gave an example of a recent situation in which a patients right to refuse treatment had been respected and upheld and another example of where a carer was trying to make a decision on behalf of another person was dealt with in line with the practices policy of consent. The consent policy also highlighted how patients' consent should be recorded in their medical notes, and it detailed what type of consent was required for specific interventions. The practice kept a register of patients who had learning disabilities.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the Clinical Commissioning Group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice required all new patients to complete a medical questionnaire; we were told patients might be called in for a medical dependent upon the information contained in the medical questionnaire. The medicals would be carried out by a GP or nursing staff employed by the practice. Patients with long-term conditions had regular recalls to check on their health and review their medications for effectiveness, ranging from annually to three monthly as appropriate. Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed about half of patients in this age group took up the offer of the health check. A GP showed us how patients were followed

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up within a few days if they had risk factors for disease identified at the health check and how they scheduled further investigations to ensure the most effective treatment pathway was identified.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed the majority had received a check up in the last 12 months. The practice actively offered nurse-led smoking cessation clinics to patients. Similar mechanisms of 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 79%, which was in line with the average across the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named staff member responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was equal to or above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice offered patients' access to the Expert Patients Programme (EPP). The EPP is a self-management programme for patients who are living with a chronic (long-term) condition. The aim is to support patients by increasing their confidence, improving their quality of life and helping them manage their condition more effectively. The practice promoted this on their website and in their patient handbook, currently almost 40 patients had signed up to this programme.

The practice kept a register of older patients who were identified as being at high risk of admission to hospital, who were taking multiple medicines or who were nearing the end of their life. An up to date care plan was in place for these patients and the information was shared with other providers such as the out of hour's service. All vulnerable older patients discharged from hospital had a follow-up consultation where it was required. Follow-up consultations were also made during routine appointments.

The majority of patients in this age range had been offered cognition testing where it was felt appropriate. Most patients with a new diagnosis of dementia recorded had a record of calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded. We saw evidence through meeting minutes of multidisciplinary case management meetings having taken place for the most vulnerable patients in this age range. Each patient over 75 years was provided with a named accountable GP.

The practice manager was a registered 'Carers Champion' and kept a register of carers for this and other vulnerable patient groups; there were currently 40 carers on the practices list. Regular contact telephone calls were made to the carers to check on their wellbeing and their ability to continue their caring role. Information signposting them to other organisations who could support them was also provided.

Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease and heart failure. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to Adastra Out of Hours system to share information and patient choice with other service providers. These patients also had access to on the day consultations to ensure their needs were met promptly.

Mother, babies, children and young people were supported by a range of appropriate services and skilled and knowledgeable staff. A Safeguarding policy was in place and monthly multidisciplinary meetings with both district nurse for adults and the health visitor for children under school age were provided. There was a system in place for school aged children involving contact from the school nurse and information sharing with the practice. Where concerns were highlighted patients were placed on either the child protection register or the child in need register.

Child immunisations were checked regularly by the nursing team. Quarterly submissions made to the 'Open Exeter' system (Open Exeter is a web-enabled viewer from NHS

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(for example, treatment is effective)

Connecting for Health that provides the opportunity to share information held on the Exeter system with other organisations including GP Providers.). The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments.

One GP had the paediatric lead, having had extra hospital paediatric experience, and was happy to review children on behalf of their partners. A Midwife held a clinic each week in the practice and sees all newly expectant mothers. They provided life style counselling which was offered to pre-expectant and expectant patient/families.

Working age patients were usually provided with their choice of appointment time, with routine practice appointments available from 8:00 am until 7:45 pm. Surgeries were also provided over lunchtimes and a phlebotomist was available every day of the week to cover lunch periods for patients to attend for blood tests. Both "book on the day" emergency and pre-bookable phone calls were also available throughout the day; the practice aimed to schedule these at mutually convenient times. If there was a lack of suitable appointments both of the practices prescribing nurses sought to fit patients in during their triage clinics to cover the patients' needs. These appointments could include a smear, chronic disease check, flu vaccination or other similar treatment. The Choose and Book system was used to offer a choice for patient hospital referrals.

Patients in vulnerable circumstances had access to a range of clinics and appointments. A sexual health clinic was provided on Monday afternoons and was both a drop in and bookable service. Health promotions such as breast screening, cytology and smoking cessation clinics were also routinely provided. Carers were encouraged to have annual health checks to ensure they remain well. The practice held a learning disability register and invited patients in for an annual health check. Senior practice GPs had extensive police surgeons experience and had also been prison service medical officers for ten years. The GPs concerned had extended experience and training in areas of drug and alcohol dependency, coupled with a stated desire to deliver quality health care to this vulnerable group. Longer appointments were available to these patients and flexibility shown if they failed to arrive for appointments on time for example by fitting them in or by offering other appointments.

Patients experiencing poor mental health who are on the practices mental health, learning disabilities, or dementia register were offered annual health checks, over half had taken up this offer. All of the GPs had emergency appointments available each day which were most frequently used for patients who were experiencing a mental health problem. A weekly Mental Health Triage Worker clinic was held at the practice for those patients who may benefit from more specialist care.

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, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' (93.4) for patients who rated the practice as good or very good. 96% of patients said the last GP they saw or spoke with was good at treating them with care and concern. The practice was also above average (96%) for its satisfaction scores on consultations with GPs and nurses with 91% of practice respondents saying the GP was good at listening to them and 90% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 38 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was slightly less positive but the comment was about the NHS generally rather than the practice. We also spoke with 16 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected at all times during appointments.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in treatment rooms with routinely washed material curtains in consultation rooms. This ensured patients' privacy and dignity was hygienically maintained during examinations, investigations and treatments. We observed that consultation and treatment room doors were closed during consultations and that conversations which took place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located behind screens which were separate from the reception desk; this helped keep patient information private when phoning the practice. There was a separate touch screen booking in station in the reception area which helped reduce queuing in the entrance area. We saw this system in operation during our inspection and saw it enabled confidentiality to be maintained. Separate rooms were available if patients wished to speak with practice staff in private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice manager told us they would investigate concerns raised and any learning identified would be shared with staff. No incidents of this type had been reported.

There was a statement to patients stating the practice's zero tolerance for abusive behaviour on the practice's website and in the waiting area.

All the comments made by patients stated they were treated by a caring and professional practice team who treated them with dignity and respect. They told us their privacy was maintained at all times and their human rights were respected.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey 2014 showed 92% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area and were reflected in the individual comments from patients during our inspection.

Good

Are services caring?

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They were satisfied with the level of information they had been given. Patient feedback on the comment cards we received was also positive and corroborated these views.

We asked staff how they made sure that patients who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service which was usually by telephone although on other occasions relatives were used. Longer appointments were booked where necessary to support patients' needs. Notices on the practices website informed patients about translation services.

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 well in this area. For example, three patients told us about how they were provided with access to emotional support services. One patient told us about how they had been provided with access to counselling and other mental health support whilst another told us about GPs giving their mobile telephone numbers to family carers so they could access guidance and support when the person they cared for was near the end of their life. We also heard how one GP would visit patients receiving palliative care out of normal practice hours and at weekends to ensure continuity of support and wellbeing.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the leaflets and booklets available for carers to ensure they understood the various avenues of support available to them. The practices website also provided carer information and links to other organisations.

The patients we spoke with on the day told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information about health conditions, health promotion and support groups.

Support was provided to patients during times of bereavement. There was evidence of sharing information for those patients who were reaching the end of their life with other healthcare professionals. Support was tailored to the needs of individuals, with consideration given to their preferences at all times. Where there was a death the practice contacted the family by phone or visited whichever was appropriate, to offer help and support. One patient gave us positive feedback regarding the help and support given to their family during a time of bereavement. Members of the patient participation group we spoke with confirmed this type of support was normal practice and said they found it comforting and helpful.

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 was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. These included, more proactive and planned support to Care Homes, a wider range of care for patients with diabetes, following a comprehensive GP education programme, care for patients with suspected deep vein thrombosis (DVT) at their local GP practice, avoiding travel to hospital, early cancer diagnosis and GPs working with other health and social care professionals to support patients who are reaching the end of their lives, understanding their needs and developing their care plans.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). Improvements included redecoration, improved information being recorded on patient notes where patients required help to access to the building, better car parking facilities and better information being made available to patients both in the practice and on the practices website. The PPG representatives we spoke with during our inspection were very complimentary about the services provided by the practice and by the staff who treated or supported them.

The practice received details of any contact the out-of-hours service had received from its patients electronically the following morning. We were told any information received was checked by a designated GP so that appropriate action could be undertaken by the right member of staff.

Turnover of staff at the practice was low. We were told some staff had worked at the practice for a considerable number of years which increased the levels of continuity of care to patients. Continuity of care was highly regarded by patients, this was reflected in the comments made to us as well as in the comments we receive on the comment cards we received.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, services for those with a learning disability, the unemployed, carers and those patients whose first language was not English. The practice had access to an interpretation service which was usually provided by telephone although on other occasions relatives were used. The practice provided equality and diversity training through e-learning for staff. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. The most effective ways of working with local ethnic groups and vulnerable patients was discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patients with disabilities where ever possible. A disabled person's parking space had been provided adjacent to the wheelchair accessible entrance to the practice. Consultation and treatment rooms were available on this level.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice, one toilet included baby changing facilities.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

The practice had made changes to their appointments system to offer patients more access to clinicians. For example, through telephone triage, telephone call slots from a requested or the patients own GP to ensure both the patient and the GP have continuity of care. Book on the day appointment slots and, slots with the patients usual GP where it was felt appropriate. Appointments were available

Good

Are services responsive to people's needs?

(for example, to feedback?)

from 8:00 am to 6:30 pm on weekdays. Additionally the practice provided extended opening hours on Monday evenings between 6:30 pm and 8:00pm. Home visits were made by the practices GPs and nurses.

Comprehensive information was available to patients about appointments on the practice website and in the detailed and informative practice information booklet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP who provided a 'ward round' approach for residents living in the home seeing those patients who needed treatment and discussing other patients in the home.

Patients told us were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how their child had become unwell overnight and they had been able to get a GP appointment that morning.

Older people and people with long-term conditions could receive home visits and longer appointments when needed. Patients we spoke with told us they valued this service. For families, children and young people appointments were available outside of school hours. The premises were suitable for children and young people with activity areas for younger children and joint working with sexual health clinics for older children and young adults.

The practice supported the working age population by providing extended opening hours. An online booking system was available and easy to use. Telephone consultations were also provided where appropriate to this group and patients were supported to return to work by the GPs and nurses through referrals to other services such as physiotherapy and counselling. Patients whose circumstances may make them vulnerable had access to longer appointments for those that need them, flexible services and appointments, including for example, avoiding booking appointments at busy times for patients who may find this stressful. Patients experiencing poor mental health or those who had longer term mental health needs were provided with longer appointments for those that need them. Patients we spoke with from this group spoke about the kindness and empathy shown by the practices GPs.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. However, the system did not include the collation of informal complaints and the lessons learnt from complaints were not formally recorded unless reviewed under the practices significant events system.

We saw that information was available to help patients understand the complaints system in the practices information booklet and on their website. The complaints system was less well explained in the waiting rooms of the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint and told us they felt confident the practice would listen and respond to their concerns. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last 12 months and found from individual records these were satisfactorily handled and dealt with in a timely way. A log of all complaints and the timeline or chronology of the complaints was not kept making complaints difficult to review annually. We saw from meeting minutes that partners discussed the complaints and ensured the staff concerned were involved in these discussions, however minutes were not made available to all staff so that learning was shared. The practice reviewed complaints annually to provide their Quality and Outcomes Framework (QOF) returns. No themes had been identified.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and saw it was shared with patients on the practices website. The practice vision and values included, always putting the patient first, providing high quality compassionate patient care, access to prompt appointments based on clinical need, timely responses to complaints and signposting patients to appropriate members of staff or other services. During the practices presentation to us they told us their aim for the coming year was to continue to give excellent care, look after both patients and staff to ensure the practice runs as smoothly as possible. They also intended to commit to services offered via the Enhanced Services system, to continue to deliver 'excellent' patient care and choice, and to maintain income for the practice, in order to remain a viable organisation in the future.

The patients we spoke with during our inspection told us the care and treatment they received was provided in line with these statements and that often the practice staff went beyond what was stated. For example, going out to visit patients in the evening or at weekends where they were unwell rather than involve the out of hour's service.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures and most staff confirmed that they had read the policies during their induction period or when a policy was updated. All six policies and procedures we looked at had been reviewed annually and were up to date. However the procedure in regard of emergency equipment did not cover the range of checks required to ensure all equipment was up to date or removed once beyond its sell by date

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with six 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. There was little movement of staff and sickness absence was low. Staff told us this promoted consistency and the practice felt they had a committed team.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly partner meetings and action plans were produced to maintain or improve outcomes. All of the patient clinical indicators are monitored and checked monthly to ensure patients in each of these areas were being offered the service and care they should be receiving.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit about records received and summarised to ensure patient records reflected the latest information. The audit showed improvement in the way information was made available promptly. Other examples included audits to confirm that the GPs who saw patients with a diagnosis of osteoporosis were doing so in line with National Institute for Health and Care Excellence guidance.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. For example, ensuring appropriate recruitment took place and that building security was managed appropriately. We saw that the risk log was discussed at relevant staff meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a 'Medicines Optimisation Pharmacist' employed by the clinical commissioning group had been commissioned to work with the practice to review prescribing so that medicines were prescribed therapeutically and risk to patients was minimised.

Leadership, openness and transparency

Are services well-led?

Good

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

The partners and nurses prioritised safe, high-quality, compassionate care and promote equality and diversity. The clinical team demonstrated and encourage cooperative, supportive relationships among staff so that they feel respected, valued and supported. This was corroborated by the multidisciplinary working the practice undertook and through events such as the training afternoons and staff team meetings.

We saw from minutes that staff meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team training and development afternoons were held quarterly. Monthly partner meetings were held to discuss all patients near to the end of their life, those diagnosed with cancer and vulnerable patients, and children where there were welfare or child protection concerns. These meetings were held with members of the district nursing team and health visitors.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example, disciplinary procedures, induction policy and absence management which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections about equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

There were high levels of staff satisfaction. Staff told us they were proud of the organisation as a place to work and spoke highly of the culture in the practice. Staff at all levels were actively encouraged to raise concerns. Staff told us the partners were approachable and how they spent time listening to what they said. They gave us examples about the practice supporting aspects of their development. However. some staff told us about the appraisals they had which identified learning or development and how this had not yet been provided.

We noted the practice was involved in a number of research programmes involving local and national universities and organisations. The GPs and nurses told us about encouraging patients to become involved in the programmes. Current research included a cream study about eczema, an oral corticosteroids study to provide clinical and cost-effective symptom relief for sore throat, a study about to developing a clinical prediction rules for both lung and colon cancer and a trial related to coughs to find out whether oral steroids could be a better treatment than prescribing antibiotics. Information about these studies was made available to patients in the waiting room so patients could make a choice about their involvement.

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

The practice had gathered feedback from patients through patient surveys, the current friends and family test, the NHS Choices website (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received) and complaints received. We looked at the results of the annual patient survey and saw patients agreed more carer information would be useful. We saw as a result of this the practice had introduced a section of their website dedicated to carer information; carer information was also available in the practice. We reviewed a report about comments from patients on March 2014, which had a common theme of the improving health promotion in the practice. The practice manager showed us improvements that had been made to information in the waiting area, and in the number and types of health promotion clinics available in or in conjunction with the practice.

The practice had a patient participation group (PPG) which had remained stable in size. The PPG included representatives from various population groups, for example, the working population and recently retired patients. The PPG had carried out annual surveys and had been meeting two or three times a year but had not met since March 2014. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff development afternoons and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. This was supported by the low staff turnover and the positive attitude shown by staff.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff development afternoons quarterly where guest speakers and trainers attended.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. **Regulation 13**