Narrowcliff Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Narrowcliff Surgery was inspected on Tuesday 10 March 2015. This was a comprehensive inspection.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring and responsive services. It was also good for well led and providing services for the six population groups. It required improvement for providing safe services.

Our key findings were as follows:

There was a track record and a culture of promptly responding to incidents, near misses and complaints and using these events to learn and change systems so that patient care could be improved. However, some policies and procedures were not being followed or monitored effectively. For example, infection control procedures did not identify the risks associated with the spread of infection and medicine processes had not being monitored to ensure checks were being carried out.

Staff were aware of their responsibilities in regard to consent, safeguarding and the Mental Capacity Act 2005 (MCA).

The practice was clean and tidy.

Medicines were managed well at the practice but temperature checks on refrigerated medicines were not always carried out and some documents required for the administration of vaccines had not been completed.

The GPs and other clinical staff were knowledgeable about how the decisions they made improved clinical outcomes for patients.

Data outcomes for patients were equal to the average locally. Where data had been identified as being lower than expected, plans were in place to improve the outcomes for patients.

Patients were complimentary about how their medical conditions were managed.

The practice was pro-active in obtaining as much information as possible about their patients which does

Summary of findings

or could affect their health and wellbeing. Staff knew the practice patients well, were able to identify people in crisis and were professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. There were good facilities available, adjustments were made to meet the needs of the patients and there was an effective appointment system in place which enabled a good access to the service.

The practice had a vision and informal set of values which were understood by staff. There was a leadership structure in place and staff felt supported.

We found areas where the provider MUST make improvements.

- The provider must protect patients and others against the risks associated with the unsafe use and management of medicines, by means of making of appropriate arrangements for the safe keeping, administration and disposal of medicines.
- The provider must ensure that patients and others are protected against identifiable risks of acquiring infection by an effective operation of systems to assess, prevent, detect and control the spread of infection.

We also found areas where the provider SHOULD make improvements. The provider should:

- Ensure systems are in place to ensure staff are aware of, follow and monitor the policies and procedures which govern activity. For example, infection control audits and procedures and medicines management. Fridge temperature management

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 requiring improvement for providing safe services.

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

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained. However, staff knowledge of infection control was not clear and infection control audits had not identified shortfalls in some furniture or the disposal of waste.

Significant events and incidents were responded to in a timely manner and investigated systematically and formally. There was a culture to ensure that learning and actions were communicated following such investigations.

Staff had awareness of the Mental Capacity Act 2005 (MCA) and of their responsibilities regarding safeguarding adults and children. All staff had received training in safeguarding awareness.

There were arrangements for the efficient management, storage and administration of medicines within the practice. However, temperature checks on refrigerated medicines and vaccines were not always conducted and some agreements had not been fully signed to allow nurses to administer vaccines and immunisations. Prescription stationary was stored and used effectively and in an appropriate way.

Staff turnover was low. Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent.

There were clear processes to follow when dealing with emergencies. Staff had received basic life support training and emergency medicines were available in the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The nursing team and dispensary staff used clear evidence based guidelines and patient directives when treating patients, however not all of these documents had been fully signed and adopted by staff at the practice.

Summary of findings

The practice used the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme. Data showed that the practice was performing equally when compared to neighbouring practices in the Clinical Commissioning Group (CCG). Plans were in place to make changes where data was lower than expected. Risks to patients were assessed and care was planned well managed.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' capacity to make informed choices about their treatment and the promotion of good health. Staff had received training appropriate to their roles.

Audits were performed and completed regarding patient outcomes, which showed a consistent level of care and effective outcomes for patients.

Patients told us staff asked for their consent before any treatment was provided.

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

The practice worked together efficiently with other services to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was positive. The patients we spoke with on the day, the comment cards we received, a friends and family survey from December 2014 to March 2015 and practice survey data reflected this feedback. Patients described the practice as caring and said they trusted the GPs, who knew them well.

We observed a person centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Accessible information was provided to help patients understand the care available to them.

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

We found the practice had a proven track record of learning from and responding in a timely way well to patient feedback, complaints, incidents and informal comments.

Patients said they could get an appointment easily in advance or with a GP on the same day.

The practice reviewed and secured service improvements where these were identified. For example, a scheme to help patients remain at home rather than being admitted to hospital.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised even if they were informal verbal complaints. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for being well led.

The practice had a formal vision and strategy which included providing a supportive accessible service within the challenges of there being an increased population during the summer months.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure in place but staff were not always clear of who held lead roles. Staff felt supported by their team leaders, the GPs and management team.

The practice had a number of policies and procedures to govern activity, although staff were not all familiar where to find these or did not always follow or monitor they were taking place. There were systems in place to monitor and improve quality and identify risk, although the monitoring of these processes was not always carried out effectively.

There was a culture of wanting to improve and learn following any significant event or complaint. Action and learning was shared with the staff involved. The practice welcomed feedback from patients through the surveys and from the virtual active patient participation group (PPG). The PPG said the management team were receptive to suggestions and feedback. Staff had received induction training, regular performance reviews and attended whole 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.

Patients aged 75 and over appreciated having their own allocated GP.

Pneumococcal vaccination, flu and shingles vaccinations were provided at the practice for older patients. Those who had problems getting to the practice or patients who lived in local care homes were given their vaccines at their home by the GP.

The GPs performed home visits for older people and for patients who required a visit following discharge from hospital. The GPs and nurse practitioner also visited patients in local care homes and nursing homes.

The practice had a system to identify older and vulnerable patients and coordinate the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life.

The practice were involved in a pilot called Pathfinder. This project was in place to protect and support frail people and older people to remain in their own homes. The practice worked with AGE UK and a group of volunteers who visit frail people and older people in their own homes to assess their overall needs. The practice also referred patients to the local day care centre.

The practice worked to help older patients remain at home and avoid unnecessary admissions to hospital.

People with long term conditions

Good

The practice is rated good for the care of people with long term conditions.

The practice identified patients who might be vulnerable, have multiple or specific complex or long term needs, to ensure they were offered consultations or reviews where needed.

Pneumococcal vaccination and flu and vaccinations were provided at the practice for those patients in an at risk group due to their long term conditions.

The practice had chronic disease nurses, who saw patients with diabetes, heart failure, hypertension, high cholesterol, asthma and chronic respiratory conditions. The nurses attended educational updates to make sure their lead role knowledge and skills were up to date. Practice staff worked with healthcare specialists to gain advice where appropriate.

Summary of findings

The practice held clinics for asthma, chronic lung disorders, diabetes, and vascular disease.

Chronic lung disease and chronic obstructive pulmonary disease (COPD) patients are issued with a rescue pack of medication to keep at home, so they have prompt access to treatment and to try to alleviate the need for a hospital admission.

The practice held monthly multi-disciplinary team meetings to discuss patients on the palliative care register and patients in the community with long term health and social needs.

The practice took part in the Newquay Pathfinder project, which was awarded an award for 'Managing Long Term Conditions' in early December 2013. The practice worked with voluntary, health and care services to offer a combination of medical and non-medical support for patients with long term conditions.

Some patients used a remote health monitoring system (Telehealth) which alerts GPs to abnormal results of tests such as blood pressure and blood glucose levels.

Patients receiving certain medicines attended for screening services at the practice, to make sure the medication they received was effective.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people

There were well organised baby and child immunisation programmes available. Primary and pre-school immunisation was well promoted within the practice. Timings of appointments had been altered to take into consideration school finishing times as a result of patient feedback from parents.

Ante-natal care was provided by a team of midwives who had regular contact with the GPs should the need arise. The practice communicated well with health visitors and the school nursing team and was able to access support from children's workers and parenting support groups. The practice communicated and had links with the local secondary school regarding teenage mental health and behavioural problems.

Families had a named GP at the practice to ensure the GP had a full understanding and knowledge of all the family.

Patients had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening for women.

Summary of findings

There were quiet private areas in the practice for women to use when breastfeeding.

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

Working age people (including those recently retired and students)

Good

The practice were rated good for caring for people of working age, including those recently retired and students.

Advance appointments up to eight weeks in advance and evening appointments were available until 7pm Monday to Friday to assist patients not able to access appointments due to their work commitments.

The practice offered a full telephone triage service to enable the working population to have access to a GP. Some follow up consultations could be carried out over the telephone at the convenience of the patient.

There was an online appointment booking system which was accessed through the website. Patients registered to use this service could book appointments with a GP up to one month in advance.

The practice had a virtual patient participation group (PPG) at the practice, which included a number of working age members. These patients used electronic communication to provide feedback to the practice.

Travel advice was available from the GPs and nursing staff within the practice.

The health care assistants carried out opportunistic health checks on patients as they attend the practice. These tests included offering referrals for smoking cessation, providing health information, blood pressure checks and reminders to attend for medication reviews.

Patients who received repeat medicines were able to collect their prescription from the pharmacy attached to the practice or could request for the prescription to be sent to a pharmacy of the patient's choice, which may be convenient to their work place.

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 had a vulnerable patient register and reviewed these patients at the multidisciplinary team meetings or more frequently as needed.

Summary of findings

The practice had a small number of patients whose first language was not English. The staff were aware of those patients who needed an interpreter and had access to a translation service.

Patients with learning disabilities were offered a health check every year. During this time, their long term care plans were discussed with the patient and their carer if appropriate.

Practice staff referred patients with alcohol addictions to a local alcohol service for support and treatment. The support service visited the practice if the patient chose this.

The practice promoted a 'no barriers approach' for patients accessing GP services, including the registration of those with no fixed abode.

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.

A register at the practice identified patients who had mental illness or mental health problems. Patients were reviewed on a yearly basis or sooner if required.

Patients had access to an in house counsellor and were monitored when they had depression and were offered regular medication reviews.

In house mental health medicines reviews were conducted to ensure patients were prescribed and received appropriate doses. Blood tests were regularly performed on patients receiving certain mental health medications.

The practice had signed up to the dementia enhanced service to increase the rates of detection for dementia. Staff used recognised examination tools used for people who were displaying signs of dementia.

The GPs held bi-monthly meetings with the mental health team to discuss patients with mental health or memory problems.

The Pathfinder project supported people with bereavement, loneliness and social isolation issues.

Practice staff supported people to access emergency care and treatment when experiencing a mental health crisis.

The practice referred patients to a local project set up for patients experiencing mental health issues. Patients accessed a six week course of support and social interaction by participation in the community.

Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection and received emails from eight members of the patient participation group.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 10 comment cards, nine of which contained positive comments. There was one negative comment about getting through on the telephone system.

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

These findings were reflected during our conversations with the 11 patients we spoke with and from looking at the practice's friends and family test results from December 2014 to March 2015 and from the practice patient survey from 2013. The feedback from patients was generally positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent. Of the 35 friends and family test results we saw two patients said they were unlikely to recommend the practice because of staff attitude and two because they preferred face to face appointments rather than speaking to a GP on the telephone during the triage consultation.

Patients were happy with the appointment system although said they sometimes had to wait for their appointment. Patients supported this feedback by saying they did not mind waiting a short time because they did not feel rushed when they were seen. We were told patients could either book routine appointments eight in advance or make an appointment on the day. We spoke with one patient who had made their 10.00am appointment at 9am that morning. They told us the receptionists had been very helpful.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Other patients told us they had no concerns or complaints and could not imagine needing to complain. Patients said they felt listened to and gave an example of making complaints about a previous telephone system which was removed after patient feedback.

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

Patients said they found it easy to get repeat prescriptions processed.

Areas for improvement

Action the service MUST take to improve

- The provider must protect patients and others against the risks associated with the unsafe use and management of medicines, by means of making of appropriate arrangements for the safe keeping, administration and disposal of medicines.
- The provider must ensure that patients and others are protected against identifiable risks of acquiring infection by an effective operation of systems to assess, prevent, detect and control the spread of infection.

Summary of findings

Action the service SHOULD take to improve

- Ensure systems are in place to ensure staff are aware of, follow and monitor the policies and procedures which govern activity. For example, infection control audits and procedures and medicines management. Fridge temperature management

Narrowcliff Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Narrowcliff Surgery

Narrowcliff Surgery was inspected on Tuesday 10 March 2015. This was a comprehensive inspection.

The practice is situated in the seaside town of Newquay, Cornwall and provides a primary medical service to approximately 12,400 patients of a diverse age group.

There was a team of seven GP partners, and one salaried GP within the organisation. Partners hold managerial and financial responsibility for running the business. There were four female and four male GPs. The team were supported by a practice manager, nurse practitioner, six practice nurses, two health care assistants and a phlebotomist (member of staff who takes blood).

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

The practice is open from Monday to Friday, between the hours of 8.30am and 7pm.

The practice had opted out of providing out-of-hours services to their own patients and referred them to an out of hours service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Detailed findings

Before conducting our announced inspection of Narrowcliff Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local Cornwall Clinical Commissioning Group.

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

We carried out our announced visit on Tuesday 10 March 2015. We spoke with 11 patients, seven GPs, seven of the nursing team and members of the management, reception and administration team. We collected 10 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

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. These alerts were circulated and discussed daily when the GPs met and at partner meetings.

Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where incidents and significant events were discussed. Records showed the practice had managed these consistently over time and so could show evidence of a safe track record. A summary of these was kept to monitor trends or patterns which may develop.

Learning and improvement from safety incidents

There was an eagerness to use any incident, accident or event as an opportunity to learn from and improve the service. The practice had a clear systematic process in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during over the year. Significant events were discussed within 24 hours of occurrence by the GPs and formally at the management meetings to make sure action had been taken and the event re-reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, it had been identified that a patient had received a medication for longer than recommended. The GPs initiated an audit to look for and review other patients on this medication to ensure it was being prescribed appropriately.

National patient safety alerts were disseminated verbally and by email to practice staff. Staff were able to give examples of recent alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received safeguarding 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 an appointed lead GP for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary advanced training to enable them to fulfil this role. Nursing staff were aware of the Mental Capacity Act 2005 (MCA) and were aware of their responsibilities.

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

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 patients with mental health issues.

There was a chaperone policy in place and posters displayed in the GPs consulting rooms. The practice was in the process of putting these posters in all treatment rooms. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Selected staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the practice and found that they were stored securely and were only accessible to authorised staff.

Medicines requiring cold storage were stored in medicine refrigerators. There was a clear policy for ensuring that refrigerated medicines were kept at required temperatures. However, this had not been followed. For example fridge temperatures had not been recorded for two consecutive periods lasting six and five months in the last year. The records that had been made showed that maximum temperatures of these fridges had reached 11 degrees on

five occasions. These gaps had been identified in the last two weeks but records did not show this process was being completed on a daily basis .Staff explained that visual checks had been carried out and provided evidence to show the fridges were fitted with alarms should the temperature go out of recommended range.

Systems were in place to check that medicines were within their expiry date and suitable for use. Expired medicines were disposed of in line with waste regulations. However, some unused medicines requiring identification as being hazardous and needing additional waste management were not being disposed of in line with national guidelines. For example, hormone preparations.

Vaccines were administered by the nursing team using legal requirements and national guidance which allows administration with individual prescription. These documents include the use of patient group directives (PGDs) which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. For example, flu vaccinations. We saw that not all PGDs had been signed by practice staff who were working under the agreement. For example, GPs and nursing staff had signed the main agreement and one individual PGD but nursing staff had not signed the other 29 PGDs. We saw up-to-date evidence to show that nurses had received appropriate training to administer immunisations and travel vaccines.

We saw evidence that medicines and prescribing patterns were kept under review as a way of improving patient safety but also as part of the local clinical commissioning group incentive scheme.

Patients were pleased with the process of obtaining repeat prescriptions.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients told us they always found the practice clean and had no concerns about cleanliness. The practice employed their own cleaning staff and had cleaning schedules in place which were monitored by the practice manager. Patients said that staff washed their hands before performing any examination or treatment.

There was a lead for infection control. However, three of the seven nursing team we spoke with were not aware who this was. All but one of the seven nursing staff we spoke with said they had done infection control training in the last year and explained this was on line training. None of the staff had performed hand hygiene audits or hand washing training.

An infection control audit had been completed in January 2015 but had not detailed which of the treatment rooms were being checked. The audit did not highlight ripped chairs within the waiting room which would make cleaning these chairs difficult. The audit did not highlight a lack of clinical waste bins within the treatment rooms for disposal of hazardous unused medicine, for example hormonal treatment. The audit did not identify that there were no spillage kits available to use should staff need to clear bodily fluids from carpets within public areas of the practice.

We noted staff wearing jewellery and clothing which would make washing hand effectively difficult.

There were flowcharts and a policy for dealing safely with a needle stick injury. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff 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 that this calibration of equipment had taken place in February 2015. All portable electrical equipment was routinely tested and had been done in March 2015.

Staffing and recruitment

Many members of staff had been in post for many years and said Narrowcliff Surgery was a good place to work. The practice had a recruitment policy that set out the standards it followed when recruiting staff. Recruitment records contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, health assessment, and registration with the appropriate professional body.

Criminal records bureau (CRB) checks through the Disclosure and Barring Service (DBS) had been performed

Requires improvement

Are services safe?

for the GPs and nursing staff working alone with young people. The practice had a risk assessment in place to explain why administration staff had not had a CRB check performed.

Staff told us about the arrangement in place to cover each other's annual leave. For example, blood tests were checked by other GPs in the absence of an individual GP. Administration staff said they had a rota to make sure all the work was covered at all times.

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

Monitoring safety and responding to risk

The practice had their own risk assessment and policy which focused on all areas of the building and had records of all servicing contracts. These included water safety, electrical equipment, gas safety, legionella, boiler safety and fire systems.

Nurses knew about how to safely dispose of general clinical waste and all staff knew how to respond in the event of a fire.

A clear system was in place to report and treat any defects or physical issues with the accommodation. Staff said the system worked well and any repairs were promptly carried out. Records were kept of routine maintenance. For example, waste management and fire safety checks.

There was a business continuity plan in place which explained what action was necessary in the event of incidents including major incidents, loss of power or outbreak of epidemic or pandemic.

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 and had this regularly. Emergency equipment was available within easy access and included 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 the emergency equipment was checked regularly by a nominated member of staff.

Emergency medicines were available at the practice were stored centrally for easy access. The medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment and patients said suggested treatments were explained in detail to them. GPs were familiar with current best practice guidance, and knew where to access guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Patients were pleased with the care, treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. The GPs and nurses completed assessments of patients' needs in line with NICE guidelines, and reviewed the care plans when appropriate.

The practice nurses and GPs led in specialist clinical areas such as diabetes, heart disease and asthma. Nursing staff and GPs were open about asking for advice and support from health care specialists, other GPs, nurse specialists and pharmacists when needed. The nursing team had experience in managing long term conditions and supported the GPs well. The practice provided evidence to show patients with long term conditions were offered reviews annually or more frequently as required.

The practice used computerised tools to identify patients with complex needs or who had multidisciplinary care plans agreed. We were shown the process the practice used to review patients who had been discharged from hospital.

National data and practice computer systems showed that the practice was in line with referral rates to hospital and other community care services for all conditions. The GPs used national standards for the referral of suspected cancers within two weeks. We saw systems used by administration staff to show how routine and urgent referrals were prioritised and made.

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, managing child protection alerts, complaints management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. For example, an audit of patients who had received intrauterine contraception devices had been performed to identify patients whose contraception devices had expired but had not been replaced. The audit identified a small number of patients who were contacted for further treatment and discussion. The practice also used complaints to trigger clinical audits. For example, a patient had complained about a medicine that was indicated for short term use. The practice immediately performed an audit to identify other patients on this audit. Six other patients were contacted about the change in their medicines and further educational sessions were organised for the GPs and nursing team. Both audits showed a full cycle to ensure learning and review had taken place.

Learning from significant events, clinical supervision and staff meetings were used to review patient outcomes achieved and areas where patient outcomes could be improved. For example, nurses had performed an audit of nursing appointment times following feedback from patients, reception staff and practice nurses. The audit had led to the introduction of designated travel clinics, purchase of new equipment and recruitment of additional staff. Staff spoke positively about the culture in the practice and said there was not a name and shame environment but events were used positively to improve services.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had scored lower than the national average for diabetes targets. This had been identified by the partners and an action plan had resulted in a meeting with nursing staff and plan to review referral patterns to the diabetes specialist nurse. The health care assistants had also been instructed to invite diabetic patients for additional tests.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with the protocol, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Patients

Good

Are services effective?

(for example, treatment is effective)

said they were sent reminders on the prescription or by letter regarding these checks and thought the system worked well. The IT system flagged up relevant medicines alerts when the GP or nurse practitioner was prescribing medicines.

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 annual basic life support and safeguarding training. There was a culture of development at the practice and all staff said they had access to the training they needed to fulfil their roles.

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).

Nursing staff and administration staff had received annual appraisals that identified learning needs from which action plans were developed. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. The practice manager received informal support from the GPs but said she had not had a formal appraisal for three years. This had been identified and a date made for this.

The practice nurse and health care assistants were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they showed evidence of their training in administration of vaccines, cervical cytology and travel advice. The practice nurses had extended roles such as non-medical prescribing, diabetes and asthma management and were able to demonstrate that they had appropriate training to fulfil these roles.

The practice was a training practice and doctors who were training to qualify as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback about the induction, support and management of the practice from the trainees we spoke with.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the out of hours service both electronically, by fax and by post. The practice manager provided a clear policy on managing these results. All staff we spoke with understood their roles and felt the system in place to communicate blood test results and hospital discharges worked well. Patient said they were informed of test results efficiently.

The multidisciplinary team could speak with the GPs when required. The district nurses, health visitors and midwives were based in the community and could discuss patients with the GP by telephone or in person. Practice staff said communication between healthcare professionals and the practice was good.

The practice held multidisciplinary team meetings each month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in the patients notes. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used 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, with patient consent, in a secure and timely manner. Electronic systems were also in place for managing cervical smear appointments and hospital referrals. Staff reported that these systems were easy to use.

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

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

We found that staff had an awareness of the Mental Capacity Act (MCA) 2005 and were aware of their responsibilities in fulfilling it. Staff had received training in the MCA 2005.

Patients said the staff asked for consent before any procedure was performed. Staff also explained this verbal check was done. Staff explained how consent was formally recorded on the patient record. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Staff were aware of the responsibilities they had when providing care and treatment to children. Nursing staff were aware of the Children Act and legal duties when 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.

Health promotion and prevention

The practice offered patients a health check when they were registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture between the GPs and nursing team to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering lifestyle and smoking cessation advice to smokers.

The practice offered the national 45-74 health checks but said the take up had been slower than anticipated. For example, the uptake had been 22%.

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 made sure they had been offered an annual health check. For example 46% of patients with a learning disability had received an annual health check so far this year.

The practice's performance for cervical smear uptake was comparable to other practices in the CCG area. Practice data showed that 75% of eligible patients had attended for a cervical smear test. Patients said the process was well organised. There was a policy to offer written reminders for patients who did not attend for cervical smears and the practice monitored the number of patients who did not attend annually. Patients said the system worked well.

The practice had systems in place to make sure patients with mental illness also had their physical health checked. For example, 95% of these patients had received a physical health check in the last year.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

There was a range of leaflets and information documents available for patients within the practice These included information on family health, travel advice, long term conditions, information for carers, drug addiction, mental health support groups and minor illnesses. The practice had a blood pressure machine in the waiting area so patients could check their blood pressure and hand the results to the GPs for analysis.

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 friends and family test and from the most recent improving practice questionnaire performed by the practice in 2013. The friends and family test results showed that of the 35 respondents 30 patients had said they would be extremely likely to recommend the practice. The national patient survey results stated that 91.4%% of patients felt that their overall experience was good or very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 10 completed cards all of which were positive about the service experienced. Positive comments included feedback on the excellent service, appropriate care, treatment and support, immediate response and caring staff. Individual staff were named by many patients.

We spoke with11patients on the day of our inspection. All told us they were satisfied with the care provided by the practice. Patients said they felt confident in the skills and knowledge of the staff and said their dignity and privacy was respected. Patients appreciated having the continuity of the same GP.

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

Staff received training on confidentiality and had recently been given reminders about the importance of maintaining patient confidentiality. 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 staff worked hard to prevent potentially private conversations between patients and reception staff being overheard.

Care planning and involvement in decisions about care and treatment

Patients told us that GPs discussed health issues 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 had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards and survey results were also positive and aligned with these views.

Staff said that the majority of patients spoke English but added that translation services were available for patients who did not have English as a first language. We saw posters in the reception area advertising this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice staff. We spoke with patients with mental health illnesses who said the support had been delivered sensitively. They said having the same GP had helped with communication and that they had received help to access support services. The patient comment cards we received were also consistent with this feedback.

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, their usual GP provided support. There were posters and leaflets offering advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a proven track record of responding to patient feedback. The practice used complaints, significant events, surveys, comment cards and face to face meetings with patients and the virtual patient participation group (PPG) to improve the service. We saw many examples of where patient feedback had influenced change. For example the survey in 2013 had highlighted patients had been unhappy about called to the treatment rooms by the tannoy system. We saw that patients were now being called to the treatment rooms by the member of staff coming to the waiting room.

The practice had an active patient participation group (PPG) who communicated by email. The group emailed us before the inspection and told us they felt the practice provided a high standard of care and responded well to questions, feedback and suggestions.

Patients said they had been asked for feedback from surveys and knew they could give feedback to the reception staff.

The practice is located in a popular seaside tourist resort Staff explained that during the summer months the town's population increases dramatically. As a result the practice provided daily 'holiday maker' appointments where patients were registered and treated as a temporary patient. We saw one comment card which explained this had happened recently with no fuss. The person stated the standard of care they had received had been very good.

Tackling inequity and promoting equality

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

The premises and services were purpose built and had been adapted to meet the needs of people with disabilities. There was level access and a designated accessible toilet which had been fitted with grab rails.

The practice had open spaces in the waiting room which provided turning circles for patients with wheelchairs and mobility scooters. Corridors and doors were wide making the practice easily accessible and helping to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with prams and allowed for easy access to the treatment and consultation rooms. There were quiet areas for breast feeding mothers and baby changing facilities available.

Access to the service

Patients were pleased with the appointment service at the practice and said they could always get a same day appointment if necessary. One patient out of the 11 we spoke with said they had experienced problems but this had been getting through on the telephone rather than getting an appointment. On the day of our visit, one patient attending the practice had made an appointment that morning and had already spoken to the GP as part of the triage system. Some comments and feedback from patients showed that sometimes patients had to wait to be seen. The patients we spoke with said this was not a problem for them as when they saw the GP or nurse they never felt rushed.

Opening hours were planned around the needs of the population. The practice was open between the hours of 8.30am and 7pm. Appointments could be booked 12 weeks in advance. Evening appointments were available each weekday to promote access to services to patients who worked during normal office hours. Patients could book appointments online which they said was very useful.

Comprehensive information was available to patients about appointments on the website and within the practice. This included how to arrange urgent appointments and home visits and how to seek medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and used this process as a part of its quality monitoring system. The practice's complaints policy and

Good

Are services responsive to people's needs?

(for example, to feedback?)

procedures were displayed in the practice and were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was a designated responsible person who handled all complaints in the practice. The practice recorded all informal and formal complaints to monitor trends and any patterns. There had been 14 formal complaints received in the last year with no clear trends identified.

We saw that all complaints had been satisfactorily handled and dealt with in a timely way. We saw evidence of learning and changes in systems, policies and processes as a result of complaints. Practice staff were keen to use comments and verbal feedback as a way of improving services. For example, one complaint regarded to a patients view that there were not enough nurses appointments available. As a result of this an audit of appointment times had been conducted.

We saw that information was available to help patients understand the complaints system. Patients were aware of the process to follow if they wished to make a complaint, but patients said they had not needed to complain.

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 an informal set of aims and objectives. Staff were able to describe the values and operational aims of the practice and included providing an accessible, caring and good quality service. Staff said they thought they met these aims.

Staff understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of staff meetings saw that staff were able to discuss and share their opinions and worked towards providing a high standard of care.

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. However, not all the nursing staff were aware of where to find these policies. For example there was an infection control policy and supporting procedures available for staff to refer to. However, some nursing staff were unaware of where these policies could be located.

There was a leadership structure in place with named members of staff in lead roles. For example, there was a GP who was the lead for safeguarding. Administration staff were aware of their leadership structure and knew who held key roles such as secretarial tasks and managing hospital referrals. Staff all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, we noted that an infection control audit had been completed in January 2015 but had not highlighted issues.

There was a clear policy for ensuring that refrigerated medicines were kept at required temperatures. However, there was no evidence to show that the policy was being monitored to ensure it was being followed. For example, fridge temperatures had not been recorded for two consecutive periods lasting six and five months in the last year. These gaps had been identified in the last two weeks but records showed that this process had not being monitored.

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 the partners meetings and action plans were produced to maintain or improve outcomes. For example, it had been identified that diabetes targets were lower than expected. The GPs had discussed this and introduced an action plan to improve outcomes and targets.

The practice held monthly governance meetings. We looked at minutes from past meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Staff described a clear leadership structure where the practice manager had a central role in the coordination of roles. We spoke with staff and they were clear about their own roles and responsibilities. Staff told us they thought the practice was well led and felt well supported and knew who to go to in the practice with any concerns.

Staff said there was an open culture within the practice and they had the opportunity and were happy to raise issues at the formal staff meetings or at any time.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment procedures and induction process which were in place to support staff. Staff knew where they could find these. This support was provided for locums who visited the practice as well as permanent staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards, direct feedback, the friends and family test and complaints received. We looked at the results of the annual patient survey and found that patients had been unhappy about the telephone number used at the practice. We saw that the main telephone number had been changed to a local call number.

The practice had an active virtual patient participation group (PPG). The PPG said they felt they could influence changes by speaking to the practice manager or GPs. Examples of changes had included successfully changing the front doors and influencing the content of the patient survey.

Are services well-led?

Good

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

The practice had gathered feedback from staff through face to face discussions, appraisals and through staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff were being consulted about the change of uniform.

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 staff files and training records and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and formally shared action and learning from these events with the staff involved to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Staff were unaware of who was lead for infection control and were not following the practice uniform policy. The infection control audit did not highlight ripped chairs within the waiting room which would make cleaning these chairs difficult. The audit did not highlight a lack of clinical waste bins within the treatment rooms for disposal of hazardous unused medicine, for example hormonal treatment. The audit did not identify that there were no spillage kits available to use should staff need to clear bodily fluids from carpets within public areas of the practice.

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 Staff were not following the policy for ensuring that refrigerated medicines were kept at required temperatures. Not all patient group directives (PGDs) had been signed by staff. These documents are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

This section is primarily information for the provider

Enforcement 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.