St Hilda's Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of St Hilda's practice. The practice is registered with the Care Quality Commission to provide primary care services.

The practice is rated as good.

Our key findings were as follows:

The practice provided services to a large geographical and rural area, the services had been

designed to meet the needs of the local population.

Feedback from patients was overwhelmingly positive, they told us staff communicated effectively and treated them with respect and kindness. Patients told us they were able to access timely appointments in the practice.

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

improvement.

We saw several areas of good practice including:

- A patient centred approach to delivering care and treatment. All staff were aware of and sympathetic to, the particular difficulties faced by the local population. The practice had taken action to bring additional services to patients to help address some of those issues.
- The practice had a good governance system in place, was well organised and actively sought to learn from performance data, incidents and feedback.
- The practice sought the opinions of staff and patients, actively working with a well-established patient participation group (PPG).

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

Importantly, the provider must:

- Improve the monitoring of expiry dates of medicines to ensure they are safe to use.

Summary of findings

- Improve the storage of blank prescriptions to ensure that these are stored in line with national guidance and kept securely at all times.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe as there are areas where improvements should be made. We identified a concern regarding the checking of the expiry date of some medicines to ensure they are safe to use. In addition blank prescriptions were not stored in line with national guidance and were not kept securely at all times. We found Staff understood their responsibilities to raise concerns, and report incidents and near misses. Processes were in place to address any identified risks.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. The National Institute for Health and Care Excellence (NICE) guidance is referenced and used within the practice. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs have been identified and planned. The staff received annual appraisals and personal development plans were considered for staff. We saw evidence of good multidisciplinary working.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice as good or very good for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness, understanding, and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP. There were urgent appointments available the same day. The practice had appropriate facilities and was equipped to treat patients and meet their needs. There were plans in place to update and expand the practice facilities to meet the needs of the growing practice

Summary of findings

population. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver their objectives. 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 regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

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. Each older patient had a named GP. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and annual health checks. The practice promoted carers support and provided signposting to local support groups and agencies. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits. The practice held regular flu vaccination clinics in different rural locations providing older patients with good access close to home. These events were also organised as social events to bring older people together in the local communities.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and nurse with structured annual review when required to check their health and medication needs were being met. When necessary these appointments were more frequent. A recall system had been introduced to identify and combine regular tests which were required by people with long term conditions. A large amount of information was available on the practice website to patients, with many links to various support organisations. Leaflets were also available at the surgery.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were good for all standard childhood immunisations. We saw that the practice held child flu clinics. In two of the CQC comment cards we received, parents told us this was effective in helping the children deal with this the process and the children were happy to return for their next immunisation. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals.

Summary of findings

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified. The practice offered good access and continuity of care to services for all patient groups. Emergency appointments, telephone consultations and early morning appointments were available. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. A new text appointment reminder system had been introduced. Staff interacted with all patients in a respectful and considerate manner.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, for example those with learning disabilities and was aware of these patients. The practice had carried out annual health checks for patients with learning disabilities and patients had received a follow-up. The practice offered longer appointments for people with learning disabilities. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The staff were aware of how to sign-post vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. There are a small number of patients whose first language is not English, the practice were able to provide access to an interpreter when required.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check and review of medicines. Patients showing signs of dementia or memory problems were screened and referred

appropriately for support and treatment. The practice could access community mental health support services. The staff were familiar with the multi-agency support service available for patients experiencing poor mental health in the local area and was able to sign post patients. The practice web site provided a large amount of information for patients and access to a range of assessments they could complete prior to making an appointment. Examples of these were the depression assessment questionnaire and alcohol questionnaire. This helped patients to understand and assess their symptoms and concerns.

Summary of findings

What people who use the service say

We received 30 completed CQC comment cards and spoke with five patients who were using the service on the day of inspection. We spoke with a range of patients from different age groups and health needs. We also spoke with three members of the patient participation group. All the patients we spoke with were extremely complimentary about the service. They told us they found the staff to be caring, supportive, and provided them with a consistently high level of care.

Patients knew they could have someone present at their consultation if required and were able to speak to staff in a private area if necessary. All patients spoken with were happy with the cleanliness of the environment and the facilities available. Patients were aware of the plans to extend and improve the practice building in Sherburn. They told us they were kept informed of all developments and we saw evidence to confirm this.

We saw that a patient survey had been completed in the practice in 2013. The responses to the questionnaire were all positive. The percentage of patients rating their ability to get through to the practice on the phone as very easy was 96%. The patients rated the practice in all areas well above the national average.

The practice had completed a Dispensary survey in 2014, a total of 136 patients using the Sherburn and Rillington practices had responded. The survey was undertaken to establish patients' satisfaction with the service and following recent comments from patients. The results of the survey were all positive and patients told the practice they were satisfied with the service. Patients we spoke with commented that they felt supported and listened to by all staff. We observed that many of the patients were known to the practice staff and greeted by name. We observed a friendly relaxed environment between staff and patients.

The practice had established a positive and proactive patient participation group (PPG). The PPG had been responsible for a range of initiatives and changes, for example conducting patient surveys, and promoting the practice and practice newsletter across the practice area.

We found that the practice valued the views of patients and saw that following feedback from surveys and the PPG, changes were made in the practice when required. The practice newsletter was used to keep patients informed of changes in the practice, promote healthy lifestyles and access to health services.

Areas for improvement

Action the service MUST take to improve

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

The storage of blank prescriptions should be reviewed to ensure that these are stored in line with national guidance and kept securely at all times.

Action the service SHOULD take to improve

Improve the practice of storing stationary in the staff toilet cubicle which would be later used in clinical areas.

Ensure the telephone wiring system in the patient toilet cubicle is not accessible to patients, particularly young children.

St Hilda's Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a CQC Pharmacist, a GP specialist adviser, and a specialist practice manager.

Background to St Hilda's Surgery

St Hilda's practice delivers primary care under a General Medical Services Contract between themselves and NHS England. As part of the NHS Scarborough and Ryedale Clinical Commissioning Group (CCG) they are responsible for a population of 5000. The practice covers an area of 250 square miles of the North Wolds. There is a branch surgery at Rillington and a weekly clinic held at Staxton village. The practice locations are Sherburn Surgery, St Hilda's Street Sherburn and Rillington Surgery, Rillington. We visited the main surgery at Sherburn and the dispensary at Rillington Surgery, we did not visit Staxton.

Services include access to four GPs (two male and two female) who do 25 surgery sessions between Monday and Friday. The practice provides early morning appointments at Rillington surgery from 7.30 am on Tuesday and Thursday mornings with access to both a GP and nurse. All patients registered with the practice can access these services. Appointments can be booked in advance for the doctor and nurse. Detailed information is available on the web site and practice brochure. Patient who require more time with the doctor or nurse are asked to book a double appointment to facilitate this.

Patients can book appointments face to face, by the telephone or online. The practice treats patients of all ages and provides a range of medical services. The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service via 111 when the surgery is closed and at the weekends. In an emergency patients are advised to ring 999 or attend the nearest accident and emergency department.

There is an all-female nursing team of two practice nurses and a nurse practitioner. The team are supported by a phlebotomist. The nurses promote healthy living; provide support for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

The practice is a dispensing practice and is supported by a team of dispensers. This service is available at both practice locations. There is a free medicine delivery service available to registered patients on Tuesdays, Thursdays and Wednesdays. Prescriptions can also be collected at the practice locations.

Both practice locations have car parking facilities and access for the disabled. Sherburn practice is unable to provide adequate disabled toilet facilities for wheelchair bound patients, however, home visits can be provided for these patients or they are advised to use the Rillington location which is fully accessible.

There were no previous performance issues or concerns about this practice prior to our inspection

Why we carried out this inspection

We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether

the provider was 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 were provided for specific groups of people and what good care looked like for them. The population groups were:

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

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked NHS Scarborough and Ryedale Clinical

Commissioning Group (CCG) and the Local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 25 November 2014. During our inspection we spoke with the staff available on the day. This included the four GP partners, the nurse practitioner, a practice nurse, the practice manager and six administration and dispensary staff. We also spoke to five patients who used the service and three members of the patient participation group.

We reviewed 30 CQC comments cards which had been completed where patients and members of the public shared their views and experiences of the service.

We observed interaction between staff and patients in the waiting room, and at the dispensary counter. We saw that staff interacted well with patients in a caring and respectful manner.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, incident reporting, 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. Staff were proactive in their approach to reporting incidents. An example of this was identifying that a sample bottle had been supplied by the laboratory with the incorrect instructions for usage. However we saw that the telephone wiring system in the patient toilet cubicle was accessible to patients, particularly young children and had not been identified as an area of concern.

The practice promoted their own comment and suggestion box which was available to patients in each practice. We saw that these were discussed at staff meetings and actioned as necessary.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including administrators, dispensers and clinical staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. All staff received the minutes of the meeting by email this ensured they had a record for reference of actions and discussions. The staff we spoke with told us the management team were approachable and promoted a positive approach to reporting problems.

The practice manager showed us the system she used to manage and monitor incidents. We saw that over the last two years 38 SEAs had been raised by staff. We tracked these incidents and saw from the records all were initially assessed and eighteen had been signed off as completed requiring no further action. We saw that incidents were reviewed several times however not all of the incident review dates were documented onto the spread sheet. We saw that incidents were completed in timely manner.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff provided examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

The Practice has a system in place for reporting, recording and monitoring significant events.

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 relevant role specific training on safeguarding. The GPs were trained to level 3 and the nursing staff had received level 2 training whilst the administration staff were trained at level one. 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 policy was available to all staff on the practice computer system. The clinical staff told us all clinical staff attended monthly safeguarding meetings.

There was a chaperone policy, with posters alerting patients visible on the waiting room noticeboard and in consulting rooms. All nursing staff had been trained in the role of chaperone. If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Are services safe?

The practice was able to identify families, children, and young people living at risk or in disadvantaged circumstances, and looked after children (under care of Local Authority).

The clinical staff confirmed they were able to identify and follow up children, young people and families. There were systems in place for identifying children and young people with a high number of A&E attendances. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently fail to attend appointments for childhood immunisations were followed up with letters and discussed with the Health visitor.

We saw that staff in the practice were long serving and that staff had a good knowledge of older people, families, children and young people, vulnerable people and the support they may require.

The practice had processes in place to identify and regularly review patients' conditions and medication. There were processes to ensure requests for repeat prescribing were monitored by the GPs.

The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We spoke with staff in the dispensaries at both surgeries and saw that they dispensed medication in a well organised and safe way.

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

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk. We observed this process was working in practice.

Staff showed us the standard operating procedures for managing medicines (these are written instructions about how to safely dispense medicines) and we saw evidence that these were regularly reviewed to reflect current practice. We observed medicines being dispensed and saw arrangements were in place to minimise dispensing errors. Medicine errors which had been supplied to patients were recorded and reviewed to reduce the risk of errors being repeated.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of directions at St Hilda's practice, Sherburn however the guidance for three vaccines at the Rillington surgery were past the date of review. We saw evidence at both surgeries that staff had received appropriate training to administer vaccines.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked at the St Hilda's practice, Sherburn were within their expiry dates, however four medicines at the Rillington surgery in the emergency bag were out of date and may not be safe to use. Expired and unwanted medicines were disposed of in line with waste regulations.

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

The arrangements for the review of medicines for patients with long term conditions were checked. Regular medicines reviews are necessary to make sure that patients' medicines were up to date, relevant and safe. Staff said that the GPs and practice nurses were responsible for these reviews.

There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. Records showed fridge temperature checks were carried out to ensure these medicines were stored at the appropriate temperature.

Are services safe?

However, we observed that room temperatures were not recorded for medicines not stored in the dispensary. This was discussed with the Dispensary Manager on the day of our visit.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice however these were not kept securely at all times.

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

The practice must improve the way they manage medicines. The expiry dates of medicines must be checked to ensure they are safe to use. The storage of blank prescriptions must be reviewed to ensure that these are stored in line with national guidance and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning staff had attended external infection control training. This provided the cleaning staff with a good knowledge of the importance of infection control. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead 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 we spoke with were aware of the importance of infection control specific to their role. Staff received infection control training and thereafter annual updates. We saw evidence that the infection control lead had carried out audits; any required improvements identified were completed in a timely manner. The nurse practitioner told us that all staff have areas of responsibility. Examples of these were regular checks of the cleanliness of the environment and cleaning of clinical equipment.

We saw that some carpets in the communal areas of the practice were stained and worn. The practice manager told us that the current building is to be expanded and re-developed shortly and these issues would be addressed. We saw information to confirm this and patients we spoke with were aware of these plans.

Stationary that would be used in clinical areas were stored in the staff toilet cubicle which could lead to an increased risk of infections being transmitted to patients. We also saw that the pillows in the examination couches were not fully protected which meant there was also an increased risk of infections being transmitted from one patient to another.

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. Staff told us how they deal with specimens received into the practice safely to minimise risk of contamination. There was also a policy for needle stick injury which staff were aware of.

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.

The practice had a policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). The practice had completed a risk assessment and there were processes in place to minimise risk.

Equipment

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 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 the fridge thermometers were regularly tested.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to

employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We saw there was a process in place for the different staffing groups to ensure there was enough staff on duty. The practice had agreed safe staffing levels. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

We saw that the practice were looking to employ an apprentice receptionist to the team and were working with a local college to ensure the member of staff received support and access to appropriate training.

We saw that the practice used a regular GP locum who was well known to the staff and patients.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had a health and safety policy which detailed areas of responsibility, training and monitoring, expected in the practice. Identified risks were included on a risk log. Each risk was assessed and actions recorded to reduce and manage the risk. An example of this was lack of wheel chair access to the practice at St Hilda's Surgery . However we did not find a risk assessment for the wiring which was accessible to people in the patient's toilet.

We saw that staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies. We saw that for all patients with long term conditions there were emergency processes in place to deal with their changing conditions. The nurses we spoke with told us that if a patient's condition is deteriorating they would increase the frequency of appointments and discuss with one of the GPs.

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

The staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice nurses told us that patients with memory problems would be assessed, their blood taken and referred to the GP. On the practice web site we saw good explanations of all conditions and assessments patients could complete if they felt they were at risk of suffering from a mental illness. The practice monitored repeat prescribing for people receiving medication for mental health needs and this was scheduled as part of their annual review.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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). All staff asked knew the location of this equipment. We saw that equipment was checked regularly.

Emergency medicines were available 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 emergency medicines were within their expiry date and suitable for use. We saw that all medicines were in date at St Hilda's practice and fit for use. However some medicines in the branch surgery at the Rillington practice were not 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

Are services safe?

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

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 the local CCG. We saw minutes of practice 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 that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. 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 lead 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. The nurse practitioner and practice nurses told us they regularly ask for advice or seek advice at the clinical meetings. Our review of the clinical meeting minutes and our discussions with clinicians confirmed that this happened.

The practice identified patients with complex needs who had or required multidisciplinary care plans and these were documented in their case notes. We saw that care plans had been developed by the GPs and staff were aware of these. The practice manager told us these were shared with patients.

The practice had a process in place to review patients recently discharged from hospital and to ensure medication changes were also reviewed. We saw that the practice continually reviewed and monitored patient's hospital admissions.

National data showed 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 to secondary care and patients with suspected cancers were referred and seen within two weeks. We saw evidence that regular review of elective and urgent referrals were undertaken by the practice.

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

Management, monitoring and improving outcomes for people

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

The practice showed us seven clinical audits that had been undertaken over the last two years. We looked at two of these audits in detail and saw that a number of audit cycles had been completed. The practice was able to demonstrate changes resulting since the initial audit. We saw that the self-management of Chronic Obstructive Airways Disease (COPD) had been improved and the practice had also improved the prescribing of a type of antibiotic. Other examples included audits of the prescribing of different medicines and the management of Hypertension based on NICE guidelines.

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 national performance measurement tool. For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines 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, the percentage of patients aged 65 and older who

Are services effective?

(for example, treatment is effective)

have received a seasonal flu vaccination is 79% which is slightly above the national average. 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 practice team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a process in place to effectively manage 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. The practice scored above average in having regular multidisciplinary case review meetings where all patients on the register are discussed.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example the percentage of patients with long standing health conditions.

Effective staffing

Practice staffing included medical, nursing, managerial, dispensary and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as fire safety and basic life support. We noted a good skill mix among the doctors having additional diplomas such as Rheumatology and Musculoskeletal Medicine and special interest in a range of services. Examples of these were family planning ,ophthalmology, minor Surgery and acupuncture

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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. All staff we spoke with were positive about the process of appraisal and the support they received from the management team and confirmed that the practice was proactive in providing training. Staff told us that the practice provided access to training, coaching and mentorship. The GPs and practice manager told us that one of the aims for the practice in the future is to become a training practice and the practice is working towards this.

The nurse practitioner and practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and the management of long term conditions. Those with extended roles such as the management of asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

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 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. We saw from the practice records that following a problem reviewing test results the practice had reviewed their

Are services effective?

(for example, treatment is effective)

process and implemented an improved process and policy to prevent reoccurrence. The practice had effective systems in place for recording information from other health care providers. Examples are discharge letters, notifications and information shared by other agencies such as care providers.

The practice had a process in place to follow up patients discharged from hospital. We saw that this was working well and there was good communication with the hospitals.

The practice held monthly multidisciplinary team meetings 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 a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). The practice receives information as to what referrals are high for particular groups and these are looked at in the practice meetings. An example of this is orthopaedics and ear nose and throat (ENT). However following review they concluded they were similar to their local peer practices.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient 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.

We saw that the practice web site and practice brochure contained information for patients about the Central NHS Computer System called the Summary Care Record (SCR). This is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had**.**

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 to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of assessment and care planning which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, 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. The patient attended for procedure at an agreed date and confirmed their consent.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse or nurse practitioner. The practice provided information about how to register with the practice and what to expect. The GP was informed of all health concerns detected and these were followed-up in a timely manner. Treatments and medication were also checked to ensure that they followed evidence based practice. The GPs and nursing staff were proactive in offering opportunistic screening for example, offering cervical screening and promoting healthy life styles.

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 they were offered an annual physical health check. The practice

Are services effective?

(for example, treatment is effective)

had also identified the smoking status of patients over the age of 16 and actively offered access to smoking cessation support to these 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 99%, which was better than others in the CCG area and nationally. It was practice policy to offer reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The practice nurses told us that they also used opportunistic screening of 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 above average for the CCG area, and again there was a clear policy for following up non-attenders by the practice nurses and health visitor.

The practice had a register of patients who were identified as being at high risk of admission and at the End of Life. The practice had developed up to date care plans which they share with other providers. We saw evidence of a good working relationship and joint working with other providers for example the local authority and local communities to meet patient need. People over 75 had a named GP to promote continuity of care and a review of medicines.

The practice had processes in place to review all unscheduled admissions to acute services. Staff were proactive in screening for Dementia and understood the importance of early diagnosis and access to ongoing treatment and support.

The practice had a register of all patients suffering long term conditions (LTC) and ensured these patients had structured annual reviews for various LTCs such as Diabetes, COPD (chronic obstructive airways disease) and heart failure. There were identified leads with expertise in the different conditions and this ensured patients received evidence based treatment. The practice QOF scores showed that the practice were preforming well for the management of all LTCs and were above the local and average. We saw that there were good working relationships with the multidisciplinary team and regular meetings to discuss patient care. The practice web site and waiting room provided good access to information about different conditions and what support was available.

There were comprehensive screening and vaccination programmes which were managed effectively to support children and young people. Staff were knowledgeable about child protection and safeguarding. The practice had processes in place to monitor any non-attendance of babies and children at vaccination clinics and worked with other agencies to follow up any concerns.

The practice also provided good information about planning and managing a pregnancy. The practice web site also linked to information on the NHS choices web site to help and support to expectant and new parents including video links.

The staff were responsive to parents' concerns and ensured parents could access emergency appointments for young children. We saw that the staff had a good knowledge of their patients and family groups and the management of childhood and adolescent illnesses. The practice also promoted contraception services for young people.

The practice provided a range of services for patients to consult with the GPs and nurses, including on-line booking, repeat prescription requests and telephone consultations.

Staff had a programme in place to make sure no patient missed their regular reviews for their condition, such as diabetes, respiratory and cardiovascular problems. Patients were able to register for text reminders for appointments. We saw that there was a good take up of NHS health checks, cervical smears and blood pressure checks.

We found that all of the staff had a very good understanding of what support services were available within their catchment area. The practice newsletter also promoted support services and staying healthy in the newsletter. Examples of these were information about carers support and saying healthy in winter.

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 212 patients undertaken by the practice's patient participation group (PPG) and a dispensary survey of 146 patients who use the service. The evidence from all of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed patients rated the service good for their overall experience of the practice.

Patients rated the service as good on consultations with doctors and nurses. 89% of patients said the GP was good at listening to them and 87% said the GP involved them in decision making**.** We saw that following the surveys action plan had been developed to improve services for patients. Examples of these are promoting the role of the nurse practitioner, telephone consultations and keeping patients informed about the new building development.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards which were, without exception positive about the service. 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. We also spoke with five patients and three members of the PPG on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that staff spoke with patients in a quiet and confidential manner. This prevented patients overhearing potentially private conversations between patients the reception and dispensary staff. We saw this in operation during our inspection and noted that it enabled confidentiality to be maintained. Patients could also ask to speak with staff in private.

Staff told us that 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 she would investigate these and any learning identified would be shared with staff.

The practice had a zero tolerance policy for abusive behaviour which they promoted to patients. The practice manager told us that she planned to arrange training in the future for staff in dealing with aggression and potentially difficult situations.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. The results from the satisfaction survey showed that 87% of patients said they were sufficiently involved in making decisions about their care.

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. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Are services caring?

We saw evidence that the practice had developed personal care plans for patients with complex needs such as some older people or end of life care. It was not clear if all patients had a copy of these plans in their homes.

We saw that the practice promoted 'You're Welcome' this is a Department of Health (DH) quality initiative to promote friendly accessible health services for young people.

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

There was information in the waiting area and on the practice web site sign-posting people to support groups, organisations and useful information. Examples of these are Carer's Direct and managing people's affairs. The practice's computer system alerted GPs and nurses if a patient was also a carer. This enabled Clinical staff to be aware of the extra support, health checks and flexibility to appointments carers may require. The practice provided forms patients could complete to assist the practice in knowing who the patient cared for. We saw further information available for carers on the practice newsletter.

Staff told us they were aware of and tried to support families who had suffered bereavement. Patients who had suffered bereavement were sent a card or visited by one of the GPs. The staff also undertook palliative care reviews and reflective practice following the death of a patient to help them improve services for people.

The practice recognised isolation as a risk factor for older patients and those in remote areas. They formed links with the local parish and village groups and promoted local activities. The practice held Flu clinics as social events in the rural communities to promote support for older people.

The PPG worked with local groups, schools and village magazines to promote awareness of and practice and promote good health. The group were involved in the Flu events and had completed a practice survey which 212 people responded to. The three members of the group we spoke with told us that they came from different geographical areas of the practice which had different needs and problems. Examples of these were isolated rural areas were access to transport maybe an issue. The practice promoted information about a local scheme which provided affordable access to transport to attend appointment at the practice or hospital.

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

I

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

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. An example of this is the plan to reduce unplanned admissions to acute care by monitoring and reviewing unscheduled admissions to acute services.

There had been very little turnover of staff in the practice which promoted good continuity of care and accessibility to appointments with a GP and practice nurses of choice. We saw that when new staff joined the practice they were introduced in the practice newsletter. An example of this was the recruitment of the phlebotomist.

The practice provided fifteen minute appointments and longer appointments were available for people who required them. Examples of these were patients with more than one LTC. This included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. Examples of these were the distribution of the practice newsletter to local schools and shops and promoting text reminders for appointments to reduce the number of do not attends (DNAs).

The practice had a palliative care register and held regular multidisciplinary meetings to discuss patients and their care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. There were regular scheduled meetings with community nurses, end of life care and other health providers.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of services, such as those with a learning disability, travellers and carers. The practice were able to identify different patient groups and respond to their needs. The practice actively promoted services available to patients in the local community, for example the flu clinics events for adults and children.

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

The premises at the main surgery did not have good access to disability facilities for wheel chair users. The practice alerted patients to this on their web site and in the practice brochure. They encouraged patients who required wheelchair access to use the branch surgery which has good disability access or ask for a home visit. The practice manager told us the disabled access will be addressed in the new surgery build. The treatment and consulting rooms in the main and branch practice are all situated on the ground floor of the building. The practice provided access to baby changing facilities.

Access to the service

The practice and dispensary are open between 8.00 am and 6.00 pm. The last appointment slot on the morning is 11.30 and appointments in the afternoon recommence between 2.45 and 3.30. The practice provides patients with detailed information about individual doctor's appointments slots in the practice brochure.

Comprehensive information was available to patients about appointments on the practice website and information brochure. This included how to arrange urgent appointments, home visits and how to book appointments through the website. The practice sign posted patients to what to do if the practice was closed and the patient required urgent medical assistance. If patients called the

Are services responsive to people's needs?

(for example, to feedback?)

practice when it was closed, an answer phone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. 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.

The practice had extended opening hours two mornings a week at the branch surgery. Bookable appointments were available from 7.30 am.

Older people and people with long-term conditions were able to access home visits where needed and longer appointments when required.

Families, children and young people were able to access appointments outside of school hours for children and young people. The practice also promoted services for young people requiring contraception and access to sexual health clinics.

The practice provided early morning appointments and up to 5.30 pm understanding the needs of students and working age population.

Online booking system were available and easy to use once the patient had registered for this service. The practice also offered text message reminder for appointments, and telephone consultations where appropriate, to support people who may be working.

The practice were aware of patients in vulnerable circumstances or with mental health needs where they may require a longer appointment or a flexible approach to booking appointments.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The practice provided patients with information about who to contact if they were dissatisfied with the response to the complaint from the practice.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. We looked at six complaints received between 2013/14 and found these were satisfactorily handled and dealt with in a timely manner.

The practice reviewed complaints and compliments on a monthly basis and where appropriate discussed them at the practice meeting. We saw that complaints were investigated, shared with staff and lessons learnt from individual complaints had been acted upon. An example was ensuring test results were promptly communicated with patients. The practice had reviewed the policy for checking test results.

I

Are services well-led?

(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. The statement of purpose for the practice states 'they have a strong commitment to providing excellent general health care to their patients'. The GPs and practice manager shared with us the practices plans to develop and expand the practice and services.

The practice manager told us that the practice will shortly be joining other local practices as part of a federation. A GP Federation is a group of practices collaborating to provide a greater range of services, improve efficiency, provide support and harness skills.

We spoke with 13 members of staff and they all knew and understood the practice vision and values. They understood what their responsibilities were in relation to these. We saw and were told that staff regularly came together at a range of formal meetings to discuss practice business, training, future developments and patient's ongoing care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We found these to be well organised which enabled the member of staff to understand how particular policies linked to the CQC regulations. This helped staff to understand the importance and relevance of each policy. We saw these policies and procedures were regularly reviewed and were up to date.

The practice held regular monthly meetings with all staff and weekly meetings with the GPs and practice manager where they reviewed performance, significant events, unplanned hospital admissions and clinically related issues. We looked at minutes from the meetings and found that performance, quality and risks had been discussed and action plans developed.

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

The practice had completed a number of clinical audits, for example COPD and antibiotic usage. The audits were shared with all clinicians and any actions required discussed.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager was responsible for maintaining Health and Safety standards inside and outside of the building. They told us they monitor, audit and deal with risk which addressed a wide range of potential issues, such as fire safety, equipment and safe access to the practice.

Leadership, openness and transparency

We saw the practice had a leadership structure which had named members of staff in lead roles. For example there was a lead for medicines management/dispensing and safeguarding lead for adult and children.

We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from meeting minutes that team meetings were regularly held. 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. The practice held meeting at a lunch time to enable all staff to attend meetings and invite multidisciplinary staff into the practice to discuss patients.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. We saw an induction policy, recruitment and management of sickness policies were in place to support staff. Staff we spoke with knew where to find these policies if required and felt confident in speaking with the management team who they told us were supportive. We found that the policies and procedures were well organised and easy to access.

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

The practice had gathered feedback from patients through patient surveys; use of suggestion boxes, complaints and compliments received which they shared with staff.

Are services well-led?

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

We looked at the results of the annual patient survey and saw the overall patient satisfaction was good with patients saying they would recommend the practice to a friend.

The PPG were active and had continually tried to promote awareness of the groups and recruit new members. The group produced an annual report and actively communicated with patients in their local area.

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

The practice had a whistle blowing policy which was available to all staff via their computers.

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 five staff files and saw that regular appraisals took place which included a personal development. Staff told us that the practice was very supportive of training and staff could access courses they required to fulfil their roles and responsibilities. The practice manager told us that they expect to have greater access to training opportunities when they become part of the local GP federation.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings when appropriate. This ensured 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **There was not an effective system in place for the monitoring of expiry dates of medicines to ensure they are safe to use. The storage of blank prescriptions were not stored in line with national guidance and kept securely at all times.**