Stoneleigh Surgery

Quality Report

Police Square, Milnthorpe, Cumbria, LA7 7PW
Tel: 015395 63307
Website: www.stoneleighsurgery.co.uk

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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	**Requires improvement**
Are services safe?	**Inadequate**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stoneleigh Surgery on 28 April 2016. Overall the practice is rated as requires improvement.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. However, we found that the practice did not have a structured process in place for them, or feedback or learning from significant events.
- There was no system in place to manage patient safety alerts.
- Risks to patients were not always assessed or well managed. For example, some of the medication in the GPs bags were out of date, there was no legionella risk assessment and there were no regular fire drills.
- There was a recruitment policy in place and appropriate recruitment checks had been carried out for staff except for one of the nursing staff who had not received a DBS check.
- Patients' needs were assessed and care was planned and delivered, however, there was no overall system in place for the practice to follow relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Data showed patient outcomes were above average for the locality. For example the overall Quality and Outcomes Framework (QOF) score for 2014/15 showed the practice had achieved 98.4% of the total number of points available to them compared to the national average of 94.8%.
- Staff were consistent and proactive in supporting patients to live healthier lives through a targeted approach to health promotion. Information was provided to patients to help them understand the care and treatment available

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had a system in place for handling complaints and concerns; however, these were not responded to formally in writing or acknowledged.
- The practice provided good access to appointments for patients. Patients told us they were able to get an appointment with a GP when they needed one, with urgent appointments available on the same day.
- Disabled facilities were limited due to constraints of the building; however the practice had taken steps to provide what services they reasonably could for patients with disabilities.
- The GP partners were not working together as a team or involved in the day to day running of the practice. However, staff did feel supported by management. The practice sought feedback from staff and patients, which they acted on.
- The practices ethos complied with the requirements of the Duty of Candour. However, the practices' record keeping process for significant events did not support the requirements of Duty of Candour.

The areas where the practice must make improvements are;

- Ensure there is structured feedback and learning from significant events.
- Ensure there is a system in place to manage patient safety alerts.
- Ensure there is a system in place to follow relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Ensure safe management of medicines, having a system in place to manage medication in the GPs bags and record the numbers of the pre-printed prescription stock which has been distributed in the practice in accordance with national guidance.
- Ensure DBS checks are carried out where appropriate.

The areas where the provider should make improvements are:

- Make the telephone numbers of the local safeguarding contacts readily available to staff.
- Consider updating the locum induction pack to contain current and comprehensive information for locum GPs working at the practice.
- Carry out a legionella risk assessment.
- Put systems in place for taking adequate written consent for some of their minor operations.
- Follow the practice complaints procedure and reply to complaints formally in writing where appropriate.

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?

Inadequate

The practice is rated as inadequate for providing safe services as there are areas where they must make improvements. Significant events were reported and recorded, however there was no structured process in place to manage them, or feedback or learning from these. There was no system in place to manage patient safety alerts.

Some risks to patients who used the services were assessed, however, the systems and processes were not implemented well enough to ensure patients and staff were kept safe. For example, some of the medication in the GPs bags were out of date, there was no legionella risk assessment and there were no regular fire drills. The practice did not record the numbers of pre-printed prescription stock in accordance with national guidance.

There was a recruitment policy in place and appropriate recruitment checks had been carried out for staff except for one of the nursing staff who had not received a DBS check. There were infection control arrangements in place and the practice was clean and hygienic, There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services; however there are areas where they must make improvements.

Data showed patient outcomes were above average for the locality. Patients' needs were assessed and care was planned and delivered. This included assessing capacity and promoting good health. The practice carried out clinical audits which were linked to the improvement of patient outcomes. Staff worked with multidisciplinary teams to improve patient care. There was evidence of appraisals for all staff and they had received training appropriate to their roles.

However, there was no overall system in place for the practice to follow relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GP locum induction pack was not comprehensive. The practice should put systems in place for taking adequate written consent for some of their minor operations.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with

Summary of findings

compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) in an attempt to secure improvements to services where these were identified. Disabled facilities were limited due to constraints of the building; however the practice had taken steps to provide what services they reasonably could for patients with disabilities.

The practice provided good access to appointments for patients. Patients said they could make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. The practice provided a number of services to patients which included minor surgery and a phlebotomy service.

The practice had a system in place for handling complaints and concerns however these were not responded to formally in writing or acknowledged.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led as there are areas where they should make improvements.

The practice had a vision for the future. They knew their top priority was to secure new premises to operate from. There were some governance arrangements in place to support good quality care; however, there were areas which needed to be improved. For example, the GP partners were not working together as a team or involved in the day to day running of the practice. Risks to patients were not always assessed or well managed. The practices ethos complied with the requirements of the Duty of Candour. However, the practices' record keeping process for significant events did not support the requirements of Duty of Candour.

There was no evidence of regular clinical meetings to encourage whole team learning and to disseminate good practice

However, the practice had an active patient participation group (PPG). Staff had received appraisals and appropriate training.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. There are aspects of the practice that require improvement which therefore has an impact on all population groups. There were, however, examples of good practice.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, patients at high risk of hospital admission and those in vulnerable circumstances had care plans in place.

The practice was responsive to the needs of older people, including offering home visits. Patients over the age of 75 had a named GP. Prescriptions could be sent to any local pharmacy and those which the practice dispensed could be delivered to the patient.

The practice provided services to one local nursing home and eight residential care homes. The patients there had the same named GP, care plans were in place and reviewed every three months and the same GP carried out medication reviews to provide greater continuity of care.

The practice maintained a palliative care register and end of life care plans were in place for those patients it was appropriate for. They offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of patients with long-term conditions. There are aspects of the practice that require improvement which therefore has an impact on all population groups. There were, however, examples of good practice.

The practice had a register of patients with long term conditions which they monitored closely for recall appointment for health checks. The practice nurses ran clinics for patients with long term conditions. They held qualifications to diploma level for various areas of chronic disease management. They had recently introduced a year of care approach for patients for managing asthma, chronic obstructive pulmonary disease (COPD) and leg ulcers. (The year of care project provides personalised care to patients to provide shared goals and action plans to enable them to self-manage their condition). There were named GP leads for each QOF chronic disease area. The practice were hoping to move to a year of care approach with other long term conditions such as chronic heart

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disease, however these patients were offered a yearly review. The practice pharmacist ran weekly clinics where patients with, for example, hypertension could receive medication reviews and monitoring.

Flexible appointments, including extended opening hours and home visits were available when needed. The practice's electronic system was used to flag when patients were due for review.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, performance for patients with COPD were above the national average (100% compared to 96% nationally).

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. There are aspects of the practice that require improvement which therefore has an impact on all population groups. There were, however, examples of good practice.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were in line with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 97%, compared to the CCG averages of 83% to 96% and for five year olds from 73% to 96%, compared to CCG averages of 73% to 98%.

The practice's uptake for the cervical screening programme was good at 86.3%, which was above the national average of 81.8%.

Appointments were available outside of school hours.

Mother and baby clinics were offered by the health visiting team at a local community centre. Child immunisations were carried out by making an appointment with the practice nurse. The practice provided a good complex range of women's services including intrauterine device (IUD also known as coil) fitting and removal service, emergency contraceptive pill service. These services aimed to reduce gynaecology referrals to secondary care.

One of the GPs and practice nurse offered sexual health advice and screening and a GP offered treatment of sexually transmitted infections.

Summary of findings

The practice provided services to the pupils at a local boarding school; they had a good relationship with the matron and had received good feedback from the parents of the children at the school.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). There are aspects of the practice that require improvement which therefore has an impact on all population groups. There were, however, examples of good practice.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services which included appointment booking, test results and ordering repeat prescriptions. Telephone consultations were available. There was a full range of health promotion and screening that reflected the needs for this age group. Flexible appointments were available as well as extended opening hours.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. There are aspects of the practice that require improvement which therefore has an impact on all population groups. There were, however, examples of good practice.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability with a lead GP in this area.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns.

The practice received a certificate from the local carers association in 2015 in recognition of their commitment to the needs of carers in the local area. The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support. There were

Summary of findings

147 patients on the carer's register which is 2.2% of the practice population. One of the GP partners was the lead for carers in the practice. Written information was available for carers to ensure they understood the various avenues of support available to them.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). There are aspects of the practice that require improvement which therefore has an impact on all population groups. There were, however, examples of good practice.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. 80.7% of patients identified as living with dementia had received an annual review in 2014/15 (national average 84%). The practice also worked together with their carers to assess their needs. Staff had attended mental health awareness training.

The practice had a process in place to manage patients who experienced poor mental health. There were different routes of support they could follow depending upon the patient. They advised them how to access various support groups and voluntary organisations. Performance for mental health related indicators was in line with the national average. For example, 88.6% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (2014/15) compared to the national average of 88.4%.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection, which included two members of the practice's patient participation group (PPG).

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included fantastic and very good. They told us staff were friendly and helpful and they received a good service.

We reviewed 31 CQC comment cards completed by patients prior to the inspection. The cards completed were all positive. Common words used to describe the practice included, excellent, good, pleasant and caring. Five comment cards although positive about the service raised unrelated concerns.

The latest GP Patient Survey published in January 2016 showed that scores from patients were above national and local averages. The percentage of patients who described their overall experience as good was 96%, which was above the local clinical commisioning group (CCG) average of 88% and the national average of 85%. Other results from those who responded were as follows;

- The proportion of patients who would recommend their GP surgery – 96% (local CCG average 81%, national average 79%).
- 98% said the GP was good at listening to them compared to the local CCG average of 91% and national average of 89%.
- 96% said the GP gave them enough time compared to the local CCG average of 90% and national average of 87%.
- 98% said the nurse was good at listening to them compared to the local CCG average of 93% and national average of 91%.
- 97% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 89% said they found it easy to get through to this surgery by phone compared to the local CCG average 81%, national average 73%.
- 89% described their experience of making an appointment as good compared to the local CCG average 78%, national average 73%.
- Percentage of patients who find the receptionists at this surgery helpful – 94% (local CCG average 91%, national average 87%).

These results were based on 139 surveys that were returned from a total of 236 sent out; a response rate of 58.9% and 2.1% of the overall practice population.

The practice had obtained feedback from their patient participation group looking at what was recommended for improvement such as introduction of a text messaging system for appointment reminders and had set a review date for when this would be achieved.

Areas for improvement

Action the service MUST take to improve

- Ensure there is structured feedback and learning from significant events.
- Ensure there is a system in place to manage patient safety alerts.
- Ensure there is a system in place to follow relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Ensure safe management of medicines, having a system in place to manage medication in the GPs bags and record the numbers of the pre-printed prescription stock which has been distributed in the practice in accordance with national guidance.
- Ensure DBS checks are carried out where appropriate.

Action the service SHOULD take to improve

- Make the telephone numbers of the local safeguarding contacts readily available to staff.

Summary of findings

- Consider updating the locum induction pack to contain current and comprehensive information for locum GPs working at the practice.
- Carry out a legionella risk assessment.
- Put systems in place for taking adequate written consent for some of their minor operations.
- Follow the practice complaints procedure and reply to complaints formally in writing where appropriate.

Stoneleigh Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a specialist advisor with experience of GP practice management and a CQC pharmacy inspector.

Background to Stoneleigh Surgery

Stoneleigh Surgery provides Primary Medical Services to the town of Milnthorpe and surrounding villages in an approximate six mile radius of the town. The practice provides services from one location at Police Square, Milnthorpe, Cumbria, LA7 7PW. We visited this address as part of the inspection. The practice is a dispensing surgery. This means under certain criteria they can supply eligible patients with medicines directly.

The surgery is located in a converted three storey building. Disabled facilities are limited and there is no car parking at the surgery. Adaptations have been put in place where possible and space is a challenge. The practice have put forward a bid with the backing of the local clinical commissioning group (CCG) for a new health centre to accommodate themselves and another GP practice in Milnthorpe. The practice has six GP partners of which five are part-time and one full time. Four are female and two male. The practice is a training practice who have GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme).There is a practice manager, a medicines manager, five dispensary staff, three practice nurses, two health care assistants a phlebotomist who also works as a receptionist and ten reception and administration staff.

The practice provides services to approximately 6600 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) contract with NHS England.

The practice is open from 8am until 6.30pm Monday to Friday. There is extended opening hours on a Tuesday evening 6.30 until 7.30pm and on Monday, Wednesday and Friday morning from 7.30am. The surgery is also open once a month on a Saturday morning from 8am until 12 noon.

Consulting times with the GPs and nurses range from 8am until 11am, 2pm until 4pm and 5pm until 6pm. On evenings when extended hours are available from 6.30pm until 7.30pm, on mornings from 7.30am and from 8am until 12 noon on one Saturday morning per month.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Cumbria Health On Call (CHOC).

Information taken from Public Health England placed the area in which the practice was located in the tenth least deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The average male life expectancy is 82 years and the female is 84. Both of these are higher than the CCG average and national averages. The average male life expectancy in the CCG area is 79 and nationally 79. The average female life expectancy in the CCG area is 82 and nationally 83. The practice has a higher percentage of patients over the age of 50, when compared to national averages. There are fewer patients than average aged between 20 and 44. The percentage of patients reporting with a long-standing health condition is higher than the national average

(practice population is 60% compared to a national average of 54%). The proportion of patients who are in paid work, full-time employment or education is 49% compared to the CCG average of 59% and the national average of 61.5%

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 and treatment, we always ask the following five questions:

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 28 April 2016.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed a sample of the practice's policies and procedures.

Inadequate

Are services safe?

Our findings

Safe track record and learning

Significant events were recorded on a template and the practice manager told us they were held by her and then looked at by the GPs at protected learning time but that this did not happen regularly. We saw from minutes from a partners meeting from February 2015 that some had been discussed but it was vague as to what had been discussed and there were no actions to take forward. We saw that there had been seven significant events in the last year. There were two different templates used by the practice to record these. Some of them did not have actions or next steps taken on the form. There was no annual review of these events. Staff we spoke with were aware of the significant event process and actions they needed to take if they were involved in an incident. The incident recording form did support the recording of notifiable incidents under the Duty of Candour. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

There was no comprehensive system in place to manage patient safety alerts. The practice manager managed the dissemination of national patient safety alerts. They decided who needed to see them. GPs picked up alerts of areas of specific clinical interest. There was no central log of action taken with them.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep people safe:

- Staff were aware of who to speak to in the practice if there were safeguarding issues. One of the GP partners and one of the nurses were the safeguarding children and adult leads. Patient records were tagged with alerts for staff if there were any safeguarding issues they needed to be aware of. The lead GP met with the health visitor if there were any concerns. Staff had all received safeguarding children and adults training relevant to their role. Both safeguarding leads had received level 3 safeguarding children training. However, there were no safeguarding policies in place for staff to refer to. There was a file with a website address for staff to refer to in case of need. There were no local safeguarding telephone numbers available for staff to look at quickly in case of need.
- There was a notice displayed in the waiting area, advising patients that they could request a chaperone, if required. The practice nurses and some of the reception staff carried out this role. They had received chaperone training. Staff who chaperoned except one of the nurses had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy, patients commented positively on the cleanliness of the practice. One of the practice nurses was the infection control lead. Staff had received infection control training. There were infection control policies, including a needle stick injury policy. Regular infection control and hand hygiene audits had been carried out and where actions were raised these had been addressed. However, a legionella risk assessment had not been carried out for the premises (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal).
- We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out. We sampled recruitment checks for both nurses and staff and saw that checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks. However, the latest nurse to be recruited did not have evidence of a DBS check. The practice manager told us their previous employer had carried one out, however, no record of the check was held. The practice manager told us that a DBS check for this staff member would be performed. We saw that the clinical staff had medical indemnity insurance.

Medicines management

The arrangements for managing medicines, including emergency drugs, in the practice were not fully satisfactory.

- The practice operated a Doctor Dispensing Service for patients that did not live near a pharmacy. Blank prescription forms were handled in accordance with national guidance. These were tracked through the practice and kept securely at all times. A process was in

place to ensure prescriptions were signed before medicines were handed out to patients. Procedures were in place for monitoring prescriptions that had not been collected. However, although actual medicines incidents and errors were recorded for learning, there was no record of 'near misses' or significant events for the purpose of review and learning from incidents.

- All dispensing staff had completed appropriate training. The GP lead for the dispensary assessed dispensing staff competency annually and opportunities for continued learning were provided through attendance at training courses. A monthly dispensary team meeting was held for staff to raise any dispensary specific issues with the GP lead. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme. The medicines manager also worked with the local CCG (clinical commissioning group) to monitor prescribing practice at the surgery in response to local and national recommendations.
- Processes were in place to check medicines were within their expiry dates and this was routinely recorded. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how these were managed. There were also appropriate arrangements in place for the destruction of controlled drugs. The dispensary fridge temperature was monitored to ensure that medicines needing refrigeration were stored at the correct temperature.
- There was a spreadsheet which was a central log of the medication in each of the GPs bags for home visits. We checked three doctors bags and for the first one the spreadsheet and medication was up to date. For the other the spreadsheet showed out of date medication, however, the medication in the bag was in date. In the third bag the spreadsheet showed out of date medication and there was out of date medication (atropine) in the bag and another medication (metoclopramide) had a damaged label so that the expiry date could not be seen. This was contrary to the practice's emergency drugs protocol which stated that they would be checked on a yearly basis.
- We saw that prescription pads were securely stored; however the practice did not record the numbers of the pre-printed prescription stock appropriately, in accordance with national guidance, once these had been distributed in the practice.
- There was a good repeat prescribing protocol in place which was written in 2015. This clearly outlined a safe process to be followed with the administration of the system, timing of reviews for different classes of medication with a special mention of high risk medication such as lithium. A practice specific analysis had been carried out of prescribing at the practice by one of the GPs. This gave recommendations for potential changes but stated it could not be achieved without clinical meetings.

Monitoring risks to patients

Risks to patients were not always assessed or well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy and risk assessment. The practice had fire risk assessments in place. Two members of staff had been trained as fire wardens. Staff had received formal fire safety training. However the practice was overdue a fire drill, it was over 12 months since one had been carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw there was a store cupboard which was accessed from a staircase used by patients which was unlocked. The practice manager said that they would get this locked immediately. The cupboard contained medical consumables such as needles, syringes and minor surgery packs. However, at the end of the inspection day this could not be done as the door would not lock and a contractor had been asked to attend the practice to repair the lock on the door.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice occasionally used locum cover. There were rotas in place for GP and administration staff cover.

Inadequate

Are services safe?

Arrangements to deal with emergencies and major incidents

All staff received basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

The practice had a business continuity plan in place for major incidents such as building damage. The plan included emergency contact numbers for staff and was updated on a regular basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There was no overall system in place for the practice to follow relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Some GPs could show us that they followed these; however there was no consistent consideration of current guidance to ensure GPs were kept up to date.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The results are published annually. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The latest publicly available data from 2014/15 showed the practice had achieved 98.4% of the total number of points available to them, with a clinical exception reporting rate of 7.2%. The QOF score achieved by the practice in 2014/15 was above the England average of 94.8% and the local clinical commissioning group (CCG) average of 96.8%. The clinical exception rate was below the England average of 9.2% and the CCG average of 10.1%.

The data showed:

- Performance for asthma related indicators was better than the national average (100% compared to 97.4% nationally). For example, the percentage of patients on the asthma register who had an asthma review within the preceding 12 months that included an assessment of asthma control was 77.4%, this compared to a national average of 75.4%.
- Performance for diabetes related indicators was above the national average (94% compared to 89.2% nationally). For example, the percentage of patients on the diabetes register who had an influenza immunisation was 95.9%, compared to a national average of 94.5%.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were above the national average (100% compared to 96% nationally). The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding twelve months was 91.9% which was better than the national average of 89.9%.
- Performance for mental health related indicators was above the national average (99.3% compared to 92.8% nationally). For example, 88.6% of patients with schizophrenia, bipolar affective disorder and other psychosis had a comprehensive agreed care plan documented within the preceding 12 months. This compared to a national average of 88.5%.
- Performance for dementia indicators was variable compared to the national average (100% compared to 94.5% nationally). The percentage of patients diagnosed with dementia whose care was reviewed in a face-to-face review within the preceding 12 months was 80.7% which was slightly lower than the national average at 84%.

Clinical audits were carried out to demonstrate quality improvement. We saw examples of four full completed audits which had been carried out in the last year. This included audits regarding intrauterine device (IUD), contraceptive coil fitting, medicines that are used to treat high blood pressure, treatment of minor injuries and an audit of accident and emergency (A and E) attendance.

The GPs had specialist clinical interests; for example, women's health including family planning and the fitting of IUD and emergency contraceptive pill service. Patients were encouraged to make an appointment with the relevant GP if they felt their expertise would be of benefit to them.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and responsibilities of their job role. There was a locum induction pack at the practice, however this contained out of date information and was not comprehensive, for example, it did not contain any safeguarding information for locum GPs to follow.
- The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings.

Good

Are services effective?

(for example, treatment is effective)

Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. Non-clinical staff had received an appraisal within the last twelve months. They told us they felt supported in carrying out their duties.

- All GPs in the practice had received their revalidation (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.)
- Staff received training that included: fire procedures, basic life support, dementia friends, customer service, health and safety, equality and diversity, safeguarding adults and children and information governance awareness. Clinicians and practice nurses had completed training relevant to their role. The practice nurses attended a local forum and shared knowledge with other practice nurses.
- The practice is a training practice who have GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme).

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

The practice nurses ran clinics for patients with long term conditions; they held qualifications to diploma level for various areas of chronic disease management. They had recently introduced a year of care approach for patients for managing asthma, COPD and leg ulcers. (The year of care project provides personalised care to patients to provide shared goals and action plans for patients to enable them to self-manage their condition). There were named GP leads for each QOF chronic disease area. The practice were hoping to move to a year of care approach with other long term conditions such as chronic heart disease, however, these patients were offered a yearly review. The practice pharmacist ran weekly clinics where patients with, for example, hypertension could receive medication review and monitoring.

Patients who were at high risk of hospital admission or who had recently had contact with the out of hours service or had unplanned hospital admissions were referred to the local care navigator who had links to a named social worker. They were employed by the local CCG. The role of the care navigator is to support those patients over 75 who are identified as at the greatest risk of a hospital admission so they maintain their independence and stay in their own homes longer when it is appropriate and safe to do so.

The GPs had a buddy system of two teams of three who buddy cover for each other for letters, results, prescriptions and tasks.

The practice had a palliative care register which was discussed at the monthly multi-disciplinary meeting and a traffic light system used to identify the most vulnerable and in need patients on the register in order to manage their treatment and support. District nurses, the care navigator and midwife were invited to these meetings.

Consent to care and treatment

Verbal consent was recorded for all minor surgery Staff understood the relevant consent and decision-making requirements, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was

Good

Are services effective?

(for example, treatment is effective)

good at 86.3%, which was above the national average of 81.8%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were in line with CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 85% to 97%, compared to the CCG averages of 83% to 96% and for five year olds from 73% to 96%, compared to CCG averages of 73% to 98%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the healthcare assistant or the GP or nurse if appropriate and health checks for the over 40s. Follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients; both attending at the reception desk and on the telephone. Curtains were provided in consulting 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.

We reviewed 31 CQC comment cards completed by patients prior to the inspection. The cards completed were mostly all positive. Common words used to describe the practice included, excellent, good, pleasant and caring.

All of the patients we spoke with were satisfied with the care they received from the practice. Words used to describe the practice included fantastic and very good. They told us staff were friendly and helpful and they received a good service.

Results from the national GP patient survey in January 2016 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 98% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 94% said they found the receptionists at the practice helpful compared to the CCG average of 91% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were above local and national averages. For example:

- 98% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 96% said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 100% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 98% said the last nurse they spoke to was good listening to them compared to the CCG average of 93% and the national average of 91%.
- 97% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. This included information regarding breast screening, child meningitis and antibiotic advice.

The practice received a certificate from the local carers association in 2015 in recognition of their commitment to the needs of carers in the local area. The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and. They supported them by offering health checks and referral for social services support. There were 147 patients on the carer's register which is 2.2% of the practice population. One of the GP partners was the lead for carers in the practice. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, depending upon the families wishes the GP would telephone or visit to offer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. For example they shared a care navigator with other practices, with the aim to improve health outcomes for patients over the age of 75.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. For example, the practice provided services to one local nursing home and eight residential care homes. The patients there had the same named GP, care plans were in place and reviewed every three months and the same GP carried out medication reviews to provide greater continuity of care.

The practice provided services to the pupils at a local boarding school; they had a good relationship with the matron and had received good feedback from the parents of the children at the school.

Services were planned and delivered to take into account the needs of different patient groups and to help to provide flexibility, choice and continuity of care. For example;

- The practice offered extended opening hours on a Tuesday evening and on Monday, Wednesday and Friday morning. The surgery was also open once a month on a Saturday morning for GP appointments.
- Telephone consultations were available if required.
- Booking appointments with GPs and requesting repeat prescriptions was available online. The dispensary could deliver medicines to the patients they provided services to.
- Text reminders by mobile telephone were available for patients.
- Home visits were available for housebound patients or those who could not come to the surgery.
- Specialist Clinics were provided including minor surgery, and travel vaccinations and podiatry which could also be arranged by home visit.
- The practice provided a good complex range of women's services including intrauterine device (IUD also known as coil) fitting and removal service, emergency contraceptive pill service, and the fitting of vaginal pessaries, which support areas of pelvic organ prolapse. These services aimed to reduce gynaecology referrals to secondary care.
- One of the GPs and practice nurse offered sexual health advice and screening and a GP offered treatment of sexually transmitted infections.
- The practice provided a phlebotomy service which included home visits if needed.
- Disabled facilities were limited due to the constraints of the building; however the practice had taken steps to provide what services they reasonably could for patients with disabilities. For example, there were alerts on the patient's computer record if they needed to be seen downstairs. The practice told us to overcome this they provided a higher rate of home visits. There was no hearing loop available. Translation services were provided.
- Mother and baby clinics were offered by the health visiting team at a local community centre. Child immunisations were carried out by making an appointment with the practice nurse.
- The practice produced a quarterly newsletter with topics and information such as; what to do with samples, appointments, patient participation group and staff news.
- One of the GP partners was the team doctor and medical officer for the local mountain rescue team.

Access to the service

The practice was open from 8am until 6.30pm Monday to Friday. There was extended opening hours on a Tuesday evening 6.30 until 7.30pm and on Monday, Wednesday and Friday morning from 7.30am. The surgery was also open once a month on a Saturday morning from 8am until 12 noon for GP appointments.

Consulting times with the GPs and nurses range from 8am until 11am, 2pm until 4pm and 5pm until 6pm. On extended hours evenings from 6.30pm until 7.30pm, on mornings from 7.30am and from 8am until 12 noon on one Saturday morning per month. However, the extended opening hours were not widely advertised by the practice, the information regarding this service was not on the practice website or in the patient information leaflet.

The practice provided good access to appointments for patients. Patients we spoke with said they did not have

Good

Are services responsive to people's needs?

(for example, to feedback?)

difficulty obtaining an appointment to see a GP and several patients who completed CQC comment cards said they could always get an appointment when they needed one. The duty doctor triaged calls for same day appointments.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages. For example;

- 86% of patients were satisfied with the practice's opening hours compared to the local CCG average of 79% and national average of 78%.
- 89% patients said they could get through easily to the surgery by phone compared to the local CCG average of 81% and national average of 73.3%.
- 89% patients described their experience of making an appointment as good compared to the local CCG average of 78% and national average of 73%.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. There were emergency appointments available on that day and the next available routine appointment with any doctor was within three working days.

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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw the practice had received three formal complaints in the last 12 months and two informal complaints, one by email and one by telephone. However, the complaints procedure stated that the patient's complaint would be acknowledged and also replied to usually in writing. None of the complaints had been acknowledged. None had been replied to in writing. The practice manager had contacted the patients all by telephone to discuss the complaint and there were temporary notes attached to the original complaint information stating what actions had been carried out with the complaint and details of the telephone call. Where mistakes had been made, it was noted that an apology had been made. The practice carried out an annual review of complaints, this documented more formally what actions had been taken with all of the complaints in the last year.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice vision was to provide the highest quality primary medical care to all patients and to encourage healthy lifestyle choices. Staff we spoke with talked about patients being their main priority.

There was no formal practice development plan or annual business planning meetings. The practice, however, knew their top priority was to secure new premises to work from which would provide more space and better disabled access for patients.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority.

Governance arrangements

There were some governance arrangements which supported the delivery of the strategy and good quality care.

- There were some practice specific policies which were implemented and were available to all staff.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There were clinical leads for areas such as safeguarding, dementia and learning disabilities and leads for chronic disease areas.
- The GPs had specialist clinical interests such as woman's health.
- QOF was used to manage performance.
- Clinical audits were carried out to monitor quality and to make improvements to patient care.

However, there were areas where improvements should be made;

- There was a staffing structure however not all staff were aware of their responsibilities, the GP partners were not working together as a team or involved in the day to day running of the practice. For example, there was no consistent consideration of current clinical guidance to ensure GPs were kept up to date.
- There was no structured process in place for significant events, or feedback or learning from them.
- The complaints policy was not followed, for example complaints were not acknowledged.
- There was no comprehensive system in place to manage patient safety alerts.
- Risks to patients were not always assessed or well managed. For example, some of the medication in the GPs bags was out of date, there was no legionella risk assessment and there were no regular fire drills.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care, however they did not work together to ensure this happened. Staff told us that they were approachable and always took the time to listen to all members of staff.

The practices ethos complied with the requirements of the Duty of Candour. However, the practices' record keeping process for significant events did not support the requirements of Duty of Candour.

There were staff meetings held at the practice. There were quarterly business meetings. General staff meetings were meant to be held monthly but only took place every other month. The practice nurses did not have meetings but there were plans for this to happen in the near future. Multi-disciplinary team meetings were held monthly but we were told the practice also wanted to improve this process. We were told clinical meetings took place monthly after protected learning time. One of the GP reports on prescribing stated that clinical meetings were not currently taking place and the set of minutes we were provided with were over a year old from February 2015.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through formal and informal complaints received and the practice participation group (PPG). The PPG had eight to ten regular members. The practice had obtained feedback from the PPG, looking at what was recommended for improvements such as introduction of a text messaging system for appointment reminders and the improvement of the appointment system. Review dates for when this would be achieved had been set.

The practice had also gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Opportunities for individual training were identified at appraisal.

Are services well-led?

Requires improvement

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

Continuous improvement

The practice had improved its appointment system and had introduced a new system in September 2015 and was receiving good feedback on how this was working. Extra appointments had been created to increase availability and variety.

The practice had introduced the year of care system for the management of some their chronic disease patients care and were achieving good QOF scores for these areas. They were hoping to introduce this model for other chronic diseases.

The practice was a training practice who had GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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 (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The practice needs to ensure there is structured feedback and learning from significant events. Ensure there is a system in place to manage patient safety alerts. Ensure there is a system in place to follow relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Ensure there is a system in place to manage medication in the GPs bags and record the numbers of the pre-printed prescription stock which has been distributed in the practice in accordance with national guidance. Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. (1), (2) (a) (b)(g)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively in order to assess, monitor and improve the quality of service provided in carrying out the regulated activities. Regulation 17 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. (1), (2) (b) (d) (i) (ii) (e)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The information specified in Schedule 3 was not available in relation to each person employed. Specifically, a practice nurse had not received a DBS check. Regulation 19 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed (3) (a)