

Clarkson 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.

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Summary of findings

Overall summary

Clarkson Surgery provides a range of general medical services to approximately 11,000 patients living in Wisbech and the surrounding villages. There is a dispensary at the practice. The practice is led by seven general practitioners (GPs) who form the partnership management team. One of the partners is the CQC registered manager of services at the practice.

We found that the practice provided an effective, caring, responsive and well led service. Improvements were needed to ensure that the dispensary operated in a safe way. Prescriptions were not always authorised before they were dispensed. The security of the dispensary needed to be improved to reduce the risk of unauthorised access. Patients at the practice had a named GP and we saw evidence of continuity of care. Patients' needs were assessed, and care and treatment was provided in line with national guidance and timely referrals were made. Staff had received training and support to undertake their roles effectively. There were systems in place to learn from incidents and complaints, although the learning from these needed to be shared amongst the entire team.

The majority of the patients we spoke with during our inspection, and received feedback from, made positive

comments about Clarkson Surgery and the service they provided, particularly in relation to the clinical care they received. The staff that we spoke with told us that they felt supported.

In advance of our inspection we talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch Cambridge about the practice. The information they provided was used to inform the planning of the inspection.

We looked at patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that overall, care was tailored appropriately to the individual circumstances and needs of patients in these groups. The practice did not provide extended hours, so access for working age adults may have been difficult for some patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice did not have appropriate arrangements in place for the safe keeping and dispensing of medicines. Staff understood their responsibilities to raise concerns and report incidents and near misses. When things went wrong, reviews and investigations were thorough. However lessons learnt were not communicated widely enough, particularly to the dispensary team.

Are services effective?

The practice was effective. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included an assessment of a person's mental capacity, where necessary and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. There was evidence of annual appraisals being undertaken or planned and there were personal development plans in place in the staff files we viewed. Multidisciplinary working was evidenced.

Are services caring?

The practice was caring. 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 also saw that staff treated patients with kindness and respect and ensured that confidentiality was maintained.

Are services responsive to people's needs?

The practice was responsive. The majority of patients reported easy access to the practice. Patients were able to obtain pre bookable appointments with their named GP or were seen on the day if their need was urgent. All patients had a named GP responsible for their care and treatment. We received positive comments from staff and patients regarding the continuity of care, and satisfaction with this. The practice had good facilities and was well equipped to treat patients and meet their needs. 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.

Are services well-led?

The practice was well-led. The practice had a clear vision to provide traditional general practice and there was evidence of this during

Summary of findings

the inspection. 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 regular meetings, and new staff received an induction, although these were not always documented formally.

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

All patients had a named GP and this included patients who were 75 years old and over. The patients who were aged 75 and over had their named GP confirmed by letter. The practice was responsive to the needs of older people and offered home visits for those who were housebound. The practice had also identified married couples who lived together who were in this age group and provided a caring role to each other, so that support could be offered quickly if either partner needed to be admitted to hospital. Monthly multi-disciplinary meetings were held to identify the best ways to provide care to older people and, where appropriate, to avoid them going into hospital.

People with long-term conditions

The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. A system was in place to regularly review patients with long term conditions and patients who did not attend were followed up. The practice provided an integrated diabetes service. A diabetes specialist nurse provided advice and visited patients, and attended meetings at the practice. We were told that this had improved the outcomes for patients with diabetes.

Mothers, babies, children and young people

Health promotion literature was available for mothers, babies, children and young people. Family planning advice and services were available from all the GPs during usual consultations. Appointments were available outside of school hours for school children to attend. The premises were suitable for children and babies. The GPs were available every day at 10am if the health visitor had any patients they needed to discuss.

The working-age population and those recently retired

The practice did not offer extended hours appointments. However, patients were offered alternative appointments where they were unable to attend during usual surgery hours. Patients had to explain why they were not able to attend during surgery hours and the practice tried to find a suitable time when the patient could be seen during surgery hours, but if this really was not possible, then patients could be seen outside of usual surgery opening hours. The facility to book appointments and request prescriptions online was

Summary of findings

available. The practice offered a full range of health promotion and screening services which reflected the needs for this age group. Patients were offered a choice when they were referred to other services.

People in vulnerable circumstances who may have poor access to primary care

The practice manager had met with the 'Gypsy Health Scheme Coordinator' and planned to increase opportunities to engage with the local traveller community. The practice staff were aware of patients from the traveller community and advised us that they supported them with their particular needs, for example completing paperwork with them. Patients with a learning disability were identified by the practice and there was a structured plan in place to offer health checks to all patients with a learning disability. We saw that information on how to refer to the learning disability community nursing team was available.

People experiencing poor mental health

Doctors had the necessary skills and information to treat or refer patients with poor mental health. Patients could be referred to an Improving Access to Psychological Therapy (IAPT) service. The practice met monthly with the mental health team to discuss and review patients with mental health needs. There was a robust process in place for the follow up of patients on intra muscular medications who did not attend for planned appointments when this medication was due to be administered. This included liaison with the mental health team. Monthly multi-disciplinary meetings were held to identify and review patients with mental health needs who required additional support.

Summary of findings

What people who use the service say

We spoke with 12 patients during our inspection. They told us that they were involved in decisions about their care and treatment and they were treated with dignity and respect. They were particularly complimentary about the clinical care they received from the staff at the practice. Two patients told us that the biggest problem they felt was patients queuing outside in the morning for an appointment.

We collected four Care Quality Commission comment cards from a box left in the practice three days before our inspection. All of the comments received on the cards were positive, in particular with regard to what patients considered to be the sound clinical care provided by the clinical staff at the practice.

We reviewed the annual patient survey for 2013 - 2014, to which 425 patients had responded. The Patient

Participation Group (PPG), (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care), had been involved in suggesting the questions that were asked. The PPG and the practice had reviewed the results, which focused on improving the speed in which telephones were answered and improving arrangements for making routine and emergency appointments. An action plan had been developed to address these areas and we saw evidence that all of the actions had been completed and had started to have a positive impact.

One of the PPG members we spoke with told us that they felt the support from the practice for the PPG could be improved.

Areas for improvement

Action the service **MUST** take to improve

Improvements must be made to the authorisation of prescriptions before the medicines are supplied to patients and the security of the dispensary to reduce the risk of unauthorised access.

Action the service **SHOULD** take to improve

The checks of the emergency medicines and equipment should be evidenced by records.

Some policy documents relating to medicine management and dispensing practices need to be reviewed, having expired in July 2014.

All relevant staff, including dispensary staff, should be made aware of the learning from significant events.

The process for the induction of new staff to the practice should be formalised and documented.

Outstanding practice

The practice were proactive in identifying people who had not previously declared themselves as a carer, for

example married couples or siblings who provided a caring role to each other, so that support could be offered quickly if either person needed to be admitted to hospital.

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Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Clarkson Surgery

Clarkson Surgery, in the Peterborough and Cambridgeshire clinical commissioning group (CCG) area, provides a range of general medical services to approximately 11,000 patients living in Wisbech and the surrounding villages. The practice is in a purpose built building and there is a dispensary at the practice.

The practice has a lower proportion of patients under 18 and a significantly higher proportion of patients aged over 65 compared to the CCG and England average. The proportion of children and older people who live in a low income household and are registered with the practice, is significantly higher than the CCG and England average.

The practice has a team of seven GP partners, who hold managerial and financial responsibility for the practice. In addition there are two GP assistants, who are medical professionals who lend GPs support in the diagnoses and management of patients. Together they provide 54 sessions per week. There are seven nursing staff, a health care assistant, six dispensary staff, eight receptionists, four secretaries and six administration staff which includes the practice manager and deputy practice manager.

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

Why we carried out this inspection

We inspected Clarkson Surgery as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed information we had received from the practice and asked other organisations to share what they knew about the practice.

We carried out an announced visit on 28 August 2014. During our inspection we spoke with a range of staff, including GPs, nursing staff, dispensary staff, reception and administration staff, the deputy practice manager and the practice manager.

We spoke with two members of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We spoke with a representative from three care homes where people were registered with the practice.

Detailed findings

We also spoke with 12 patients who used the service and talked with carers. We reviewed four comments cards where patients had shared their views and experiences of the practice. We observed how people were supported at the reception and at the dispensary. We reviewed a range of documentation which related to the provision of care and treatment of the patients registered at the practice.

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Are services safe?

Our findings

Safe patient care

The practice used a range of information to identify risks and improve quality in relation to patient safety. There were clear accountabilities for significant event reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 2 years. The practice held a significant event review meeting yearly to review the most significant events and those where the most change had been needed. This showed the practice had managed these consistently over time.

We saw that there was a procedure in place to ensure that safety information was shared appropriately within the practice. Staff were informed of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. We saw evidence that safety alerts had been disseminated and appropriate action had been taken and recorded. The GPs we spoke with told us that they circulated emails internally when there were changes to guidance. We saw an example of this with changes in guidance in relation to contraception.

Learning from incidents

The practice had a system in place for reporting, recording, investigating and monitoring incidents and significant events. We reviewed a number of significant events and found that these had been reviewed, investigated and learning points identified. These were discussed during the partners' meeting and in the staff meeting. There was evidence of investigation and learning, and improvements had been made. For example, following a reported incident, we saw that there was a robust system in place to ensure that home visit requests were documented and had been allocated to a GP.

The practice had recorded a small number of medication errors since the start of 2014 and we noted records of discussions about these incidents at staff meetings. However two dispensing staff that we spoke with were unaware of an incident in February 2014 that was relevant to them. We could not be assured that if an error

arose, that dispensing staff would be made aware and appropriate learning actions taken. We found that the process for sharing the learning within the practice could be improved.

Safeguarding

The practice had a system in place to help ensure that patients were safeguarded against the risk of abuse. We reviewed their safeguarding adults policy and safeguarding children policy. Additional guidance was available for staff which included for example, safeguarding adults good practice guide and General Medical Council (GMC) guidance on protecting children and young people. Contact information for safeguarding professionals external to the practice was also available. Staff we spoke with had an understanding of the different types of abuse and how they would respond if they had a concern.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children who had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

The nurse told us that any patient or child who was on the child protection register or known to be at risk or vulnerable were 'flagged' on the system so that all staff dealing with the patient were aware that additional support may be necessary.

A chaperone policy was in place and patients were advised of this service via notices in the practice. We were told by the practice manager that nursing staff acted as chaperones and this was confirmed by the clinical staff we spoke with.

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. For example, there was a fire risk assessment audit which had been completed on 25 June 2014 and hazards had been identified. An action plan to address these areas was in place. A current fire appliance service certificate was available. We saw records that showed that the majority of staff were up to date with health and safety training. We saw evidence that a planned training session for fire safety awareness had been booked for September 2014.

Are services safe?

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary itself was well organised and operated with adequate staffing levels. Most feedback we received indicated patients were happy with the supply of their repeat prescriptions and reported no delays in obtaining their medicines. The dispensary offered a medicine delivery service to its patients. We observed that staff were helpful to patients and handed them their medicines following safe procedures for checking their identity. However, we saw that repeat prescriptions were handed to patients without proper authority or consultation with the doctors and that the medicines were supplied to patients before prescriptions were signed by the doctors. This was unsafe practice.

We asked about the arrangements in place for the security of medicines. We noted that medicines, including injectable medicines, were kept securely in clinical areas of the surgery. However, we also noted that arrangements for the security of keys to the dispensary were not sufficiently robust and keypad codes were not regularly changed to ensure only authorised staff could access the dispensary. In addition, we found that the arrangements for the secure storage and record-keeping practices to account for blank prescription forms were not robust. We noted blank prescriptions could be accessed by undesignated members of staff which is not in line with published guidance. In addition, we could not be assured that if prescriptions were lost or stolen this could be promptly identified and investigated.

We looked at records of temperatures for medicines requiring refrigeration. We noted one refrigerator in the treatment room had been above the accepted temperature range for the storage of medicines requiring refrigeration, on three days in the last month. This had been raised with the practice manager before our inspection and steps had been taken to order a replacement vaccination refrigerator. In the dispensary, records showed temperatures had been maintained below the accepted temperature range. It was unclear if this was due to staff recording errors. Therefore we could not be assured medicines requiring refrigeration had been stored properly and were still safe and effective for use. The practice nurse on duty described adequate arrangements for maintaining the cold-chain for vaccines following their delivery.

We checked a sample of controlled drugs and found we could account for them in line with registered records. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. We also noted that dispensary staff conducted and recorded controlled drug checks on a regular basis.

The practice had arranged regular weekly visits by a pharmacy technician who provided regular training for dispensing staff and contributed to prescribing reviews and audits. Dispensing staff sometimes prompted reviews of medication by the doctors. We found that dispensers also made changes to patients' prescribed medication following the receipt of external correspondence, for example a hospital discharge letter. These changes were not always shown to and agreed with the GP before they were dispensed, so we could not be assured changes had been safely made.

We noted that dispensary staff had received training appropriate to their role. However the competence of dispensing staff in relation to all areas of their role had not recently been assessed. The practice manager confirmed that arrangements were in place for this to be carried out during September 2014.

A policy and procedure folder was available in the dispensary for staff to refer to about standard operating practices. We found some policy documents relating to medicine management and dispensing practices had recently been updated, however, there were others listed that were still awaiting review having expired in July 2014.

Cleanliness and infection control

We observed that all areas of the practice were visibly clean. We saw cleaning records which confirmed that all areas were cleaned daily and this was documented. Nurses reported that they cleaned their clinical surfaces following each consultation. We looked at three cleaning audits that had been undertaken in August 2014 and found that areas for improvement had been identified and action taken to address these areas where appropriate. For example we saw evidence of a quote being obtained to re plaster the wall after a recent leak to the roof.

The practice had an identified infection control lead and an infection control policy, which staff we spoke with were aware of. Hand washing facilities were available and we saw posters were displayed promoting good hand hygiene.

Are services safe?

We saw that personal protective equipment was available for all staff. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice manager had made enquiries in relation to the need for legionella testing at the practice and was awaiting a response. (Legionella is a germ found in the environment which can contaminate water systems in buildings.) The practice had undertaken an internal risk assessment and the risk was low. Following our inspection we spoke with the practice manager who confirmed that an external company had agreed to undertake this testing.

Staffing and recruitment

The practice had a number of policies and protocols that set out the standards it followed when recruiting staff. Records we looked at confirmed that appropriate recruitment checks had been undertaken prior to employment. We noted that for one member of staff one reference had been taken up, rather than two. We were advised that this was a decision based on the first reference.

The practice manager told us that GPs were on the performers list, which meant they had already had a Disclosure and Barring Service (DBS) check. Disclosure and Barring Service checks help to ensure a person's suitability to work with vulnerable patients. The practice manager had identified there was no confirmation in the GP staff files that a DBS check had been undertaken, so they had requested a DBS check for each of the GPs. Following the inspection the practice manager confirmed that most of these have been received.

The practice manager had a system in place for checking and recording the registration status of the clinical staff annually. This included checking the registration of the nursing staff with the Nursing and Midwifery Council, and the GPs with the General Medical Council.

We were told there was a rota system in place for all the different staffing groups, to ensure there was enough staff on duty. We were told by the practice manager how staff in the different departments, for example reception and

administration covered for each other in times of staff shortage. For example, there was an arrangement in place for members of reception and administration staff to cover each other's role and they were trained to be able to do this. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Dealing with Emergencies

Staff recognised and knew how to respond to urgent and emergency situations. The practice had oxygen available and an automated external defibrillator. This is an electrical device that provides a shock to the heart when necessary. We saw that the surgery also had a small supply of medicines for use in emergency which were safely stored. We were told that these were checked but there were no records available about medicine expiry date checks or that the stock level was checked and maintained. The majority of the clinical and non-clinical staff were up to date with training in basic life support and using an automated external defibrillator. Training had been booked in November in order that all the staff were up to date with this training.

There was a disaster handling and business continuity plan available which identified a range of risks, and actions to take in the event of those risks occurring. Risks identified included for example, loss of computer system, loss of building, loss of electricity and loss of water supply. The document also contained relevant contact details for staff to refer to. For example, contact details of the electricity company in the event of a loss of electricity.

Equipment

We saw the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose a range of conditions patients might present with. The equipment was in good order. There was evidence that electrical equipment had been tested for electrical safety. Medical equipment had also been regularly recalibrated, where necessary.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment in line with standards

The GPs and nursing staff we spoke with clearly outlined the rationale for their treatment approaches. They were familiar with current best practice guidance. The practice manager emailed National Institute for Health and Care Excellence (NICE) guidance to relevant staff and this was discussed in clinical meetings. We saw minutes of clinical meetings where new guidelines had been discussed.

The clinicians we spoke with confidently described the processes to ensure that consent was obtained from patients whenever necessary. We were told that verbal consent was recorded in patient notes where appropriate. Written consent forms were in place for minor surgery. Clinicians were aware of the requirements of the Mental Capacity Act (2005) used for adults who lacked capacity to make specific decisions. They also knew how to assess the competency of children and young people to make decisions about their own treatment.

We saw that patient correspondence and test results were reviewed by the patients named GP in a timely way and actioned appropriately. We were told that if GPs were not at work then they had a designated buddy who undertook this work on their behalf. The GPs met at the same time on a daily basis for an informal discussion for clinical support and administration issues between the GPs. There was evidence that timely referrals were made and the staff we spoke with confirmed that they were totally up to date with all their referrals. We saw that some choose and book referrals had been generated during our inspection.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 98.7 out of a possible 100 points.

Management, monitoring and improving outcomes for people

We did not see any evidence of completed clinical audit cycles, however we were told by one of the GPs that a clinical audit had been undertaken which related to contraception.

One of the GPs in the surgery carried out minor surgical procedures in line with their Care Quality Commission (CQC) registration under the Health and Social Care Act (2008) and NICE guidance. We were told by the practice manager that the GP who undertook these procedures was appropriately trained and kept up to date with the latest safe practice and guidance. They also regularly audited their results and used these in their learning and development.

The delivery of care resulted in positive outcomes for patients. The practice worked with other health and social care services in order to deliver an 'integrated' diabetes service, for patients with diabetes. A diabetes specialist nurse provided advice and visited patients, and attended meetings at the practice. We were told by one of the GPs that this had improved the outcomes for patients with diabetes. The nurses we spoke with told us they were involved in the management of patients with long term conditions, for example asthma and diabetes and there was a system in place to ensure that patients were recalled at the appropriate times for a review. We were told by one of the GPs that they had worked with the local commissioning group to develop a rapid response team. This team, led by a community matron, were alerted to patients who needed additional health or social care support in order to remain at home, rather than being admitted to hospital. This had resulted in patients remaining at home, following swift intervention by a community matron.

Effective staffing, equipment and facilities.

Practice staff included medical, nursing, managerial dispensary, reception and administrative staff. We reviewed a selection of staff training records and saw that the majority of staff were up to date with completing the practice's mandatory training courses, for example safeguarding children and adults, information governance, equality and diversity, basic life support, fire and health and safety. The practice manager told us that every other

Are services effective?

(for example, treatment is effective)

month an external trainer visited the practice team to deliver training to staff at lunchtime. Staff also had access to online training for training that was deemed mandatory by the practice.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. The practice had employed nurses with specific skills and training in chronic conditions such as asthma and diabetes and chronic obstructive pulmonary disease (COPD) in order to meet the needs of the patients.

All staff received annual appraisals which identified learning needs from which action plans were documented. The practice manager told us that they used to undertake all the appraisals but that this had recently changed and the lead in each department undertook the appraisals, with the practice manager appraising the leads. Staff in the dispensary told us that they had not received their appraisal for this year. We spoke with the practice manager who showed us evidence that these had been scheduled to occur within the next two weeks, although the dispensing staff had not yet been informed. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example a repeat prescribing course for the prescribing clerk.

Working with other services

We saw evidence that multidisciplinary meetings were held every month and were attended by practice staff and professionals from a range of services, such as social services, the mental health team, falls prevention team, community matron and district nurses. We looked at the minutes of the previous meeting and saw evidence of collaborative working to optimise care and support for patients. The practice also held a palliative care meeting every other month which was usually attended by a Macmillan nurse, district nurse, community matron, GP, practice manager and deputy practice manager. We saw evidence that patients at the end of their life were reviewed comprehensively and appropriate support was put in place.

The practice manager told us that they had tried to have regular meetings with the health visitor but this had proved difficult due to the capacity of the health visitor. However they had established a system where the health visitor had open access to the GPs at 10am every working day, via their clinical computer system.

The nurses told us that clinicians had access to a system which allowed patients' medical notes to be available to all health professionals providing patients gave consent. This allowed the practice to see when patients had been admitted to hospital during out of hours or had been seen by other members of the health team.

Health, promotion and prevention

It was practice policy to offer all new patients who registered with the practice a health check with the nursing team, to establish patients' needs and review medication. There was a systematic process for carrying out new patient health checks which was robust, past medical history and family history were reviewed. If patients had specific medical conditions they were also seen by their GP to ensure their care and treatment needs were assessed and appropriate plans were put into place to meet their needs.

Immunisation and vaccination clinics were held by the practice nurses and there was an effective follow up system in place for patients who did not attend. The practice offered NHS health checks to all its patients aged 40 to 75 years. The practice also carried out cervical screening in line with the national programme. The nurses we spoke with reported that they provided general support and advice as and when required, for a range of health promotion subjects, for example, smoking cessation, contraception, immunisation and other health issues. They also reported that they signposted patients to other services when necessary for example, the genitourinary medicine clinic or health visitor.

The practice had 36 patients identified on their learning disability register and we were told that there was a structured plan in place to offer health checks to all patients with a learning disability.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed positive interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. Most of the patients we spoke with, or received comments from, confirmed that staff were friendly and caring in their approach.

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

There was a system in place to support patients and those close to them to receive emotional support from suitably trained staff when required. For example near the end of a person's life and during bereavement. Bereaved family members were offered the opportunity to speak with a GP. There was information available at the practice to signpost patients to bereavement support groups. One of the patients we spoke with felt extremely supported by the practice in relation to the bereavement support they had received.

Involvement in decisions and consent

Staff involved patients in decisions about their care and treatment. The clinical staff we spoke with told us that they

provided information to support patients to make decisions about their care and treatment. In addition, they gave patients the time they needed to ensure they understood the care and treatment they required. They told us that they ensured that the patients always understood the procedure to be carried out. The patients we spoke with and the comments cards we received confirmed this. Patients also told us that their views were listened to.

Guidance was available to staff about a consent protocol and confidentiality in relation to teenagers. When interviewed, clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We saw the practice Mental Capacity Act (MCA) (2005) policy. (The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so). This provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. The MCA policy did not contain the direct contact details for the independent mental capacity advocate, but advised of another service from which the contact details could be obtained. This meant that there may be a delay in contacting this service when this may be needed. All staff were aware of patients who needed support from nominated carers, and clinicians ensured that carers' views were listened to as appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

We were told by one of the GP partners that there had been a stable staff team at the practice for over 20 years and as a consequence they knew many of the patients. The GPs at the practice had personal lists which meant that all patients were allocated to a named GP who was responsible for the oversight of their care. This ensured continuity of care and provided a personalised level of service. Patients who we spoke with, or received comments from, were satisfied with the level of clinical care they received from the practice.

Access to the service

Information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent and non-urgent appointments and home visits and how to book appointments via the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients via the website, the practice leaflet and it was on display at the practice.

Appointments at the practice could be made online, by telephone or in person. Appointments were available in four sessions during the day, between 8.30am and 10am, 10.40 am and 12 noon, 2pm and 4pm and 3.30pm and 6pm, although not all doctors provided appointments at all of these times. Patients were advised to pre book appointments at a suitable time with the GP they were registered with, for continuity of care.

The practice was trialling a new system for patients who called for an on the day appointment, after all these appointments had been allocated. Patients were contacted by telephone, by a GP, who undertook an assessment over the telephone. Patients were given an urgent appointment for the same day, a non-urgent appointment, or if their need was urgent and could be dealt with over the telephone, then this was undertaken by the GP. For example, a patient who urgently needed a repeat prescription could be dealt with over the telephone.

Most of the patients we spoke with, or received comments from, told us they were satisfied with the appointment system and were able to see a GP when they needed to and at a time suitable for them. Two of the patients we spoke with told us, that there was often a queue outside in the morning to get an appointment, as it was difficult to get through to the practice by telephone at this time to book an appointment. The practice was aware of this and had upgraded the telephone system. Patients were now informed of their position in the queue and more staff were able to answer the call and the lines coming into the practice could be shared.

The practice had patients registered from nine care homes, across a large rural geographical area. When a home visit was requested by a patient in a care home, then this was undertaken by the patient's named GP. Home visits that were requested by housebound patients were also undertaken by their named GP. If a home visit was requested after 12 noon then this was undertaken by the duty doctor. We spoke with staff from three care homes and overall the feedback was positive. However one member of staff from one of the care homes told us of an occasion when it had been problematic getting a patient seen by a GP, when they became ill after 10.30am.

Meeting People's needs

The practice was situated in a purpose built, ground level building, with level access for patients with wheelchairs and prams. There were reserved car parking spaces for disabled patients. Accessible toilet facilities were available for all patients attending the practice. Patients could check in at the reception desk or at a self check-in screen, which was available in four different languages. There were a number of waiting areas, which were large enough to accommodate patients with wheelchairs and prams, and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence.

The majority of the staff at the practice had completed equality and diversity training. Staff were aware of the different needs of their patients and they provided examples of when they provided support appropriate to the needs of the patient. For example, we were told that reception staff would help patients to complete registration forms if the patient was not able to read or write.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had access to a telephone translation service and this was offered to patients. There was also a GP at the practice who spoke Russian.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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. This was available in the practice information leaflet which was given to all new patients when they registered. This information was also available on the practice website. There was a separate patient information leaflet which detailed the complaints procedure. This provided information on an advocacy service which could help patients to complain.

We looked at five complaints received in the last 12 months. We found that these had been acknowledged, investigated and responded to in line with the practice complaints procedure. The responses had occurred in a timely manner and we saw that an apology was given where this was appropriate. However, information on the escalation of complaints to the Parliamentary and Health Service Ombudsman, if patients were dissatisfied with the response from the practice, was not always provided.

The practice reviewed complaints on an annual basis to detect themes or trends. This was undertaken at an annual complaints meeting which was attended by all staff. We looked at the report for the last review and although no themes had been identified, lessons had been learnt from the six individual complaints, and had been acted upon.

Are services well-led?

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

Our findings

Leadership and culture

The vision of the practice was to provide a traditional general practice service with named doctors for all patients, which delivered high quality care and promoted good outcomes for patients. Although this was not written down, it was evident during our inspection, through talking to staff and patients. There was effective leadership and recent changes had been made to strengthen the management of different departments within the practice.

Governance arrangements

There were clearly identified areas of GP lead responsibility for areas such as the dispensary, infection control, child safeguarding and adult safeguarding and complaints, information governance, training and education.

Practice meetings were held every three weeks and were attended by the GPs, the practice manager and the deputy practice manager. We looked at the previous minutes and noted that a range of clinical and non-clinical items were discussed. We were told that senior meetings were held quarterly and were attended by all the GPs, the practice manager, the deputy practice manager, the lead nurse, senior receptionist and information technology lead. The last meeting that had occurred was on the 8 January 2014. We were told that there had not been a senior meeting since then due to recent changes in the management of the different departments within the practice. We looked at the minutes of the meeting and the areas discussed included specific issues occurring in the different departments and how they could be improved. Staff team meetings were held every three months.

Systems to monitor and improve quality and improvement

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copy in the practice manager's office and in reception. Electronic copies were available although we were told by the practice manager that most staff accessed the paper copies. We looked at a number of these policies and procedures and most had been reviewed regularly and were up to date. Staff we spoke with knew where to find these policies if required.

Patient experience and involvement

The practice provided notices at reception and in the waiting areas which asked patients what they thought of the practice. New patients were also given a copy of the notice when they registered at the practice. Patients were asked to submit their email address and were then sent information to seek their views on the practice. The patients who had provided their email address were part of an online Patient Participation Group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

We reviewed the annual patient survey for 2013 - 2014, to which 425 patients had responded. The online Patient Participation Group (PPG) had been involved in suggesting the questions that were asked. The PPG and the practice had reviewed the results, which focused on improving the speed in which telephones are answered and arrangements for making routine and emergency appointments and had developed an action plan to address these areas. We saw evidence that all of the actions had been completed and had started to have a positive impact.

One of the PPG members we spoke with told us that they felt with the support of the practice the PPG could be improved.

Staff engagement and involvement

We saw the staff team meetings were held every three months and all staff were invited to these meetings. We looked at the previous meeting minutes and the areas covered included, general practice matters, significant events, health and safety, complaints, taking messages from patients. We saw evidence that staff had contributed to the agenda and to the meeting. 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 staff we spoke with told us they were able to discuss any concerns or issues with colleagues and management and felt that they would be listened to. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training

Are services well-led?

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

and mentoring. We saw that the nurse prescriber had a weekly meeting scheduled with one of the doctors who was identified as their mentor. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared learning with staff via staff meetings to ensure the practice improved outcomes for patients. However we found that this learning was not always effectively shared with staff in the dispensary.

Identification and management of risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice manager had noted the dates of when checks had occurred and were due, which included for example, equipment calibration, fire

equipment testing and document review dates. The processes in place to monitor the reviews dates of the standard operating procedures in the dispensary were not robust, as we found some policy documents relating to medicine management and dispensing practices were still awaiting review having expired in July 2014.

A range of risk assessments were undertaken at least yearly, including for example, fire, health and safety and disabled access. We saw evidence that risks had been identified and action taken to minimise their potential impact. For instance there was a contingency plan to deal with loss of utility services in the building. Feedback on the outcome of the risk assessments were raised at the partners meeting for information, discussion and agreement on the associated actions.

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	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines</p> <p>Patients were not protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the safe keeping and dispensing of medicines.</p>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	