Wollaston Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection of Wollaston Surgery on 23 October 2014. Wollaston Surgery is a registered location of the provider Dr Marathe and Partner. This provider has one other registered location, Brookside Medical Centre which we did not inspect at this time.

This was a comprehensive inspection. Wollaston Surgery achieved an overall rating of good. This was based on all of the five domains and six population groups we looked at achieving the same good rating.

Our key findings were as follows:

- Patients were satisfied with the service and felt they were treated with dignity, care and respect.
- Systems were in place to maintain the appropriate standards of cleanliness and protect people from the risks of infection. The practice was clean.
- Patients spoke positively about the system to access a GP without making an appointment.
- The practice had a process to ensure best practice was followed. This helped ensure people's care, treatment and support achieved good outcomes.

There are also areas of practice where the provider needs to make improvements.

In particular the provider should:

- Have a written record of discussions at staff meetings
- Have a system to clearly identify staff training needs and record training which has been completed
- Assess the safeguarding training needs for non clinical staff
- Have policies and processes which reflect and comply with the requirements of legislation and directives
- Complete any outstanding actions arising from risk assessments
- Confirm clinical supervision and appraisal arrangements for staff

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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

The practice had appropriate facilities and was well equipped to treat patients and meet their needs. Information about how to

Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders had taken place.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was not active but the practice had plans to have one by April 2015. Staff had received inductions. Not all staff had received regular performance reviews but the practice had plans to complete these. Staff attended staff meetings and events

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

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to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had supported patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 36 completed CQC comment cards and spoke with seven patients. Patients we spoke with and who completed our comment cards were very positive about the care and treatment provided by the GPs, clinical staff and other members of the practice team including the reception staff. Patients who had been with the practice for a number of years said they trusted the GPs and clinical staff as they knew their medical history and provided appropriate care. They told us that they were treated with respect and their privacy and dignity were maintained.

Patients told us that they liked the open access to a GP without the need to make an appointment and commented that this arrangement worked well to see a GP on the day usually within 30 minutes of their arrival.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. 122 patients of the 262 invited to participate returned a completed questionnaire (47% return rate). Overall patients told the survey that they liked the services provided and expressed a high satisfaction level in the open access to a GP without an appointment. They also commented that the GPs could improve the way they explained tests and results to them and involve them more in their care and treatment.

Areas for improvement

Action the service SHOULD take to improve

- Have a written record of discussions at staff meetings
- Have a system to clearly identify staff training needs and record training which has been completed
- Assess the safeguarding training needs for non clinical staff
- Have policies and processes which reflect and comply with the requirements of legislation and directives
- Complete any outstanding actions arising from risk assessments
- Confirm clinical supervision and appraisal arrangements for staff

Wollaston 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 and a practice manager acting as specialist advisers.

Background to Wollaston Surgery

Wollaston Surgery provides a range of primary medical services for people of Wollaston in Northamptonshire. The practice serves a population of 4800. This is a rural practice and the population is predominantly White British.

Clinical staff at this practice includes two GP partners and two nurses. The team is supported by a practice manager, three reception staff and a Medical Secretary. A health visitor midwife and a district nurse also support the practice.

Out of hours care when the practice was closed was through the NHS 111 service.

Why we carried out this inspection

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

We carried out this inspection 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 practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

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

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

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

Detailed findings

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the local Clinical Commissioning Group (CCG), the Local Medical Committee (LMC) and NHS England. We carried out an announced visit on 23 October 2014. During our visit we spoke with a range of staff, including GPs, reception staff, nurses and the practice manager. We spoke with patients who used the service. We observed how patients and family members were dealt with and collected comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw that staff had reported an incident where a refrigerator that was used to store vaccines had not maintained the safe storage temperatures and had withdrawn the stored vaccines from use.

We reviewed safety records, incident reports and complaints. The practice manager told us that these were discussed during practice staff meetings. We did not see any minutes of meetings and the practice manager explained that on account of the small team, only actions arising from these meetings were posted as task on staff computer screens through the practice's electronic records management system.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There was a record of a significant event that had occurred in the last year and we were able to review this. Significant events and complaints were discussed during staff meetings. We did not see any minutes of meetings and the practice manager and other practice staff we spoke with explained that on account of the small practice team, only actions arising from these meetings were posted as tasks on staff computer screens.

We were shown the complaints analysis for the 12 months period ending October 2014. We saw that the practice had analysed complaints received and had implemented improvements. For example as a result of issues raised with the time allocated for telephone consultations, the practice had introduced protected time at the end of each practice for the patient to consult with the GPs. We did not see any individual complaint folders as these had been shredded recently in preparation for the imminent sale of the practice.

There was evidence that the practice had learned from the significant event we reviewed and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at staff meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by electronically to practice staff. Staff we spoke with were able to tell us about a recent alert concerning Ebola which was relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All clinical staff had received relevant role specific training on safeguarding. Training records were not centralised and clinical staff kept records of their training in their own individual learning files. Non clinical staff had not received role specific training on safeguarding. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained to the appropriate level to enable them to fulfil this role. The lead GP told us that they would attend child protection case conferences if necessary. However they told us that there had been no referrals made either for adult or child safeguarding in the past four years. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. We saw that there was a chaperone policy and staff we spoke with told us that only nursing staff acted as a chaperone.

The practice worked closely with the health visiting service and liaised with this service in following up children and young people who attended A&E. Children who persistently failed to attend appointments such as for childhood immunisations were followed by the Child Health Services of the local NHS community trust.

Good

Are services safe?

The practice had a system for reviewing repeat medications for patients with multiple medications. We saw records that showed us that 88% of patients have had this medication review.

Medicines management

Medicines were stored securely in the medicine refrigerator and were only accessible to authorised staff. The refrigerator temperature was checked so medicines were kept at the required temperatures. Staff knew what action to take in the event of a potential failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice reviewed its prescribing data as part of its performance against the Quality and Outcomes Framework (QOF). The QOF is a national funding tool linked to performance measurement for services provided by GPs. We saw that the patterns of antibiotic and hypnotics prescribing were comparable to national prescribing patterns.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an advanced nurse practitioner and nurse prescriber.

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

Cleanliness and infection control

We found the premises clean and tidy. We saw that there were cleaning schedules in place and cleaning records were kept. Patients told us that they found the practice clean and had no concerns about cleanliness. We observed that a toilet for patient use was also accessible to a disabled patient.

The practice had a lead GP for infection control. All staff received induction training about infection control specific to their role. We did not see any evidence of regular infection control training updates. We saw evidence of a recent infection control audit and noted that improvements identified for action had been completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury,

Notices about hand hygiene techniques were displayed around hand washing facilities. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in consulting and treatment rooms.

The practice had a process for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing calibration of equipment was in place. We saw evidence of calibration of relevant equipment such as weighing scales.

Staffing and recruitment

The practice had a recruitment policy which highlighted the need to make checks of references, qualifications, registration with the appropriate professional body and, criminal records through the Disclosure and Barring Service (DBS) before a new employee started work. The policy however did not make explicit reference to a check of the applicant identity. The practice may wish to amend this policy so this reference is explicit.

Good

Are services safe?

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

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

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. These included periodic checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. We saw evidence of a recent building fire risk assessment, legionella check and fire alarm tests. The practice had a health and safety policy. We saw records of a health and safety risk assessment done in December 2013. However some actions arising from this assessment were still outstanding, such as a check of the panic alarm situated in each patient consultation room and fire drills for staff. The practice may wish to arrange these as soon as possible.

Identified risks were recorded. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at staff meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

The practice had a single point of contact for emergency consultation for patients with long-term conditions. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were weekly meetings between the district nurse and the GP and other professionals as appropriate where the specific needs of people with long term conditions such as chronic obstructive airways disease (COPD) and asthma were discussed in order to minimise any unplanned hospital admissions.

There were arrangements in place for identifying acutely ill children and young people. For example on the day of our inspection, a GP asked a parent who was concerned about the health of a young child to bring that child into the practice whilst the practice was closed for lunch break, so the child could be examined and given appropriate treatment.

Patients experiencing a mental health crisis were referred to the local mental health NHS trust so they could access emergency care and treatment. Where appropriate patients were also referred to the Wellbeing team operated by the local NHS mental health trust, which provided self-help therapies for people who needed help with their mental health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. The practice used a system called 'Pathfinder' which incorporated all such guidance and offered up-to-date access to diagnosis, treatment, monitoring and referral criteria to other services in one place.

The GP told us that when new guidelines were disseminated, the implications for the practice's performance and patients were highlighted to clinical staff through a 'task' alert system on the practice's computer system. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the nurses supported this work, which allowed the practice to focus on specific conditions. The practice nurse told us that they were given opportunities to advance their knowledge, for example they had attended a course in diabetes management in December 2013. We saw certificates that confirmed this.

We saw data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar size practices. The practice had also completed a review of case notes for patients who received medicines to manage their heart failure with a view to optimising the use of beta-blockers and ACE inhibitors which are medications used to treat conditions such as angina, heart failure and high blood pressure.

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

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. Clinical audits are a way of identifying if healthcare is provided in line with recommended standards, whether it is effective and where improvements could be made. Examples of clinical audits included those on the use of medicines to treat heart failure, consent and infection rates following minor practice. The practice had a plan for re-audit and we saw that one of the audits had already been re-audited and had shown an improvement in clinical practice as a consequence.

The practice also used the information they collected from the quality outcomes framework (QOF) about their performance against national screening programmes to monitor outcomes for patients. QOF is a national funding tool linked to performance measurement for services provided by GPs. For example QOF performance information showed that the practice met all the minimum standards for diabetes, asthma and chronic obstructive airways disease (COPD) care. This practice was outside the accepted reference range for the QOF clinical target of dementia diagnosis rate for patients in residential care homes. The GP we spoke with however told us that they did not provide care for any patients in residential or nursing homes so this target did not apply.

Staff told us that clinical supervision and staff meetings were usually used to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. There were no formal clinical supervision arrangements for the two qualified nurses, but they told us that the GPs always offered them supervision when needed as they operated an open door access policy.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice worked with the community nursing services and provided end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support

Good

Are services effective?

(for example, treatment is effective)

needs of patients and their families. The practice also had a carers register which enabled them to understand the needs of the patient and their carers. Carers were invited as a minimum yearly for a review of their needs and where appropriate were supported by social services in this review. When a patient was deceased, the GPs offered their relatives and carers an opportunity to talk through any issues that they may have had.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We noted adequate skill mix among the doctors with each of the two GPs having additional interests for example in sexual and reproductive medicine, diabetes, children's health and asthma. All GPs were up to date with their yearly continuing professional development requirements and were awaiting a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Both the practice manager and the staff we spoke with said they benefitted from a 'blame-free' culture that emphasised the opportunities for learning from any adverse incidents or events as opposed to disciplinary action in most cases. However, we saw evidence that there was also an effective system in place for managing variable or poor performance when this was required.

Working with colleagues and other services

The practice worked with other service providers to manage and meet people's needs. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a process for reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We spoke with GPs and nursing staff who demonstrated that communication and work with other agencies took place on a regular basis. We saw evidence of a variety of meetings involving other services for example, health visitors and midwives. There was evidence of co-ordinated integrated pathways, for example care of people who needed end of life care.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used the electronic Choose and Book system to make referrals. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

All the information needed to plan and deliver care and treatment was securely stored electronically and was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. Information stored electronically was only accessible to relevant staff through a password system. This electronic system allowed relevant staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a policy for obtaining consent from patients to their care and treatment. The GP told us that patients were provided with information about their care and treatment and that this took various forms. Generally information was provided verbally and consent was also sought in the same way and recorded on patients electronic records at the time. Some treatments were explained with the help of leaflets or written information printed off the computer. Some procedures required written consent, such as flu vaccines and contraceptive implants. The emphasis was on ensuring patients understood what they were going to experience and seeking their consent. We saw evidence that the practice had audited the effectiveness of the consent procedure for contraceptive implants.

Mental capacity assessments and 'best interests' decisions were referred to the GPs who made these in consultation with patients' families. A 'best interests' decision relates to

Good

Are services effective?

(for example, treatment is effective)

people whose ability to consent is limited due to their diminished capacity. However, the practice manger acknowledged that there was no formal training in the Mental Capacity Act 2005 offered to staff.

In relation to children and young people under 16, particularly in matters related to family planning and sexual health, we found that the staff had a good understanding of the need for the consent of someone with parental responsibility (PR). Further, the staff understood the specific criteria used to assess a young patient's competence to consent if treatment was requested in the absence of someone with PR. In those instances where that competence might be in doubt, patients were referred to one of the GPs.

Health promotion and prevention

The practice operated patient registers and nurse led clinics for a range of long term conditions (chronic diseases) and there was a nominated GP lead for each of these. The practice offered practical advice for example on eating well & exercise, smoking cessation, chlamydia screening and prostate cancer.

The practice maintained a register of patients with learning disabilities and we saw that they were offered an annual health check in 2014.

We found that the practice offered a number of services designed to promote patients' health and wellbeing and prevent the onset of illness. We saw various health related information was available for patients in the waiting area. This included information on dementia, flu vaccination, mental health, and keeping warm in winter.

The practice had participated in targeted vaccination programmes for older people and those with long term conditions. These included flu vaccination for people with long term conditions and those over 65.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance Last year's performance for all immunisations was in line with similar surgeries.

There was a named GP for patients over 75 years of age and the practice had implemented proactive care plans for 2% of these patients who were assessed as high risk of hospital admissions. 88% of older people that received multiple medications (polypharmacy) had an annual medication review.

People with long term conditions for example diabetics, were offered periodic foot and eye checks. The care needs of patients who were admitted frequently to a hospital were discussed in multidisciplinary weekly meetings with the GP, the district nurse and other professionals so their care could be better managed at home without the need to attend hospital. We saw records of such meetings.

For working age people the practice offered cervical smears and blood pressure checks. Performance information we reviewed showed that the practice met all the minimum standards for cervical smears and blood pressure checks.

People experiencing poor mental health were signposted to relevant support groups such as the wellbeing team provided by the local mental health NHS Trust.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, Of the 262 patients that were invited to participate 122 returned a completed survey. The findings showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. However, only 66% of patients reported that they would recommend the practice to someone new, which was below the CCG average of 77%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four comments were less positive but there were no common themes identified. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice reception desk was shielded by glass partitions which helped keep patient information private. However on account of the small reception and patient waiting area a conversation in private was not always possible. The receptionist explained that patients were offered an adjoining room to discuss any sensitive information.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 77% of practice respondents said the GP involved them in care decisions and 73% said the last nurse they saw or spoke with was good at involving them in decisions about their care which was above average compared to other surgeries in the CCG area. However a lower number 73% felt the GP was good at explaining treatment and results which was marginally below average compared to other surgeries in the CCG area. The practice is currently working on ways of improving patient satisfaction.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw a notice in the reception area informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients told us that they had received help to access support services to help them manage their treatment and care when it had been needed. The comment cards we received were also consistent with what the patients told us. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, and practice website also gave information on how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice maintained a carer register and reviewed their needs periodically.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

A counselling support service (called the Wellbeing Service operated by the local NHS mental health trust) was also available to provide emotional support to patients either by referral by the GP or self-referral by the patient.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The GPs and practice nurses had developed areas of special interest and expertise and provided appropriate services for the practice population. These included considering the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities, children and older people. Specific services provided included nurse led chronic disease management clinics, antenatal clinics, well baby clinic, minor practice, family planning service, wellbeing clinic and immunisations. These services could be booked in advance.

Patients we spoke with and comments card we saw indicated that patients were appreciative of the open access system to GP consultations. Patients told us that this system offered the guarantee of seeing a GP without having to telephone for an appointment. They also told us that sometimes they would wait for up to 30 minutes before they saw a GP but they generally accepted that wait as they were able to see a GP on the day they wanted.

The practice had also implemented changes to the way it delivered services in response to feedback from the GP patient survey. For example GPs and nurses had been reminded through staff meetings to involve patients in decisions about their care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They had taken into account the differing needs of people by planning and providing care and treatment services that were individualised and responsive to needs and circumstances. This included having systems in place to ensure that patients with complex needs, such as a learning disability or dementia were able to access appropriate care and treatment.

People in vulnerable circumstances were able to register with the practice. The practice manager told us that people with 'no fixed abode' such as patients from a local traveller' community could access the services the same as any other patient.

The practice had access to telephone interpreter services. Patients who needed this service were taken to a poster in the patient waiting area where they could point to the specific language they spoke. The reception staff then made appropriate arrangements to access this service.

The premises and services had been adapted to meet the needs of people with disabilities, such as a toilet suitable for physically disabled patients. This toilet also doubled up a nappy changing facility.

Access to the service

The practice did not operate an appointment system for consultations. The practice was open between 8.30am and 6.30pm Monday to Friday. The GPs were available for consultation between 9am and 10.30am, 4.30pm until 5.30pm Monday to Friday except on a Wednesday afternoon when there was no GP consultations available. The practice also offered a variety other services such as nurse led chronic disease management clinics, antenatal clinics, well baby clinic, minor practice, family planning service, wellbeing clinic and immunisations. These services operated during normal surgery hours including on a Wednesday afternoon. These services could be booked in advance. If a patient wished to talk to a GP instead of a face to face consultation then they could telephone between 11.30 am & 12 noon Monday to Friday. House bound patients, older people and people with long-term conditions could request a home.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number of the out-of-hours service to patients.

We reviewed the 36 completed CQC comment cards that patients left for us. Patients commented positively in respect of being able to access the service. We also looked the results of the 2014 GP survey which confirmed the comments patients had made. 94% of the respondents

Good

Are services responsive to people's needs?

(for example, to feedback?)

found it easy to get through to the practice by phone. 97% said the last appointment they got was convenient and 85% said the last GP they saw or spoke to was good at giving them enough time.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day and told us that most of the time saw the doctor of their choice. The 2014 GP survey confirmed this where 81% of respondents with a preferred GP usually got to see or speak to that GP.

The practice's extended opening hours during weekdays from 4.30 to 5.30 pm afforded better access for patients who work, or school children or those who could not attend during normal opening hours.

Listening and learning from 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. There was a complaints poster displayed and a summary leaflet was available. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a summary of the 3 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the compliant.

Are services well-led?

Good

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

Our findings

Vision and strategy

The GP partners described to us a clear value system which provided the foundations for ensuring the delivery of a high quality service to patients. The culture at the practice was one that was open and fair. Discussion with members of the practice team generally demonstrated this perception.

The practice' strategy was shaped by the need to adapt service provision to meet the demands of local people, including delivery of the clinical targets agreed with the local clinical commissioning group and meeting the minimum standards set in the Quality Outcome Framework. The practice met regularly with the local clinical commissioning group and worked jointly to improve on services provided.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff meetings. The GPs and practice staff told us that performance, quality and risks had been discussed. They explained that on account of the small size of the team, minutes were not kept but actions arising from these meetings were posted as 'tasks' on individual staff member's computer screen to note and act on. Staff we spoke with recognised the need for improved communication and records between all the staff groups and GPs. The practice may wish to start keeping formal notes of staff meetings in addition to posting 'task' notes on actions to be taken.

Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to challenge existing arrangements and improve the service being offered. These arrangements supported the governance and quality assurance measures taken at the practice and enabled staff to review and improve the quality of the services provided.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at staff meetings and plans were produced to maintain or improve outcomes.

The practice had a system for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw three examples of clinical audit relating to medicines used to treat heart failure, obtaining consent for contraceptive implants and infection rates following minor practice. All had prospective re audit dates identified with one already completed.

Leadership, openness and transparency

As the practice was small leadership arrangements were led by the two GP partners. Each member of the practice team were aware of their responsibilities. For example there was a lead for infection prevention and control, and another for safeguarding. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at staff meetings or through one to one meetings with the GP or the practice manager.

The practice manager was responsible for human resources, policies and procedures. We reviewed a number of policies, for example the infection control policy, and the recruitment and selection policy. While these policies were current, we did not see any reference to legislation and directives which determined policy requirements. For example in the recruitment and selection policy we did not see a reference to the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which required a photo identity check. A GP explained that policies currently reflected what was done and did not necessarily reflect the requirements of legislation and directives. They agreed that all policies would be reviewed and appropriate references will be made the requirements of legislation and directives.

Seeking and acting on feedback from patients, public and staff

The practice participated in the NHS 2014 GP patient survey. This survey reflected high levels of satisfaction with

Are services well-led?

Good

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

the care, treatment and services provided. The practice had taken action following this survey for example to improve the way treatment and results were explained by the GP to the patient.

The practice does not have a patient participation group (PPG). A GP explained that because of the rural location, setting up this group had presented many challenges. They hoped to have a functional PPG by April 2015. A patient suggestion/comments box was provided in the reception area as well as on the practice website. The practice manager told us that no comments have been posted in either media to date.

The practice had gathered feedback from staff through staff meetings and informal discussions. They told us they had no problems in approaching colleagues and management and that their contributions were respected and valued.

The practice had a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Nurses told us that the GPs had supported them as and when they needed it, and operated an open door access for support.

We asked about staff appraisals. The practice manager told us that two nurses had been appraised since 2013 but no other staff. This was because of the uncertainty associated with the imminent sale of the practice after which the practice manager expected defined appraisal arrangements for all staff. The practice may wish to consider interim arrangements for the continuation of appraisals for all staff pending any prospective sale. Such an appraisal could help develop a training plan for the whole practice.

The practice was a GP training practice and had previously been assessed by an external assessment visit by the deanery for approval as a training practice. Previous visits had led to renewal of the approval for a further three years. Presently there were no trainee GPs attached to this practice on account of the imminent sale of the practice and the retirement plans of the partners.

The practice had completed reviews of significant events incidents and complaints and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example improvements were made to the way patient's medications were reviewed as a result of a significant event review.