The Orsett Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Orsett Surgery on 14 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive services and well led. It was also good for providing services for older people, people with long term conditions, families, children and young people, working aged people (including those recently retired and students), and people with mental health (including people with dementia). The practice required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses within the practice. Improvements were needed to ensure that staff were aware of procedures for raising and reporting concerns to external agencies including local the safeguarding team.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Improvements were needed to ensure that risks to patients and staff were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with empathy, compassion, dignity and respect and they were listened to and involved in making decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. Complaints were investigated and responded to in a timely and appropriate way.
- Patients said they found it easy to make an appointment with a named GP and that there was

Summary of findings

continuity of care, with urgent appointments available the same day. Referrals to secondary care services were made appropriately and in a timely manner in line with local and national guidance and targets.
- The practice had good facilities and was well equipped to treat patients and meet their needs. However improvements were needed to ensure that services were accessible and suitable for patients with mobility or other physical disabilities or impairments.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider MUST:

- Ensure that patients are protected against the risks of unsafe care by the safe management of medicines and ensuring that staff receive appropriate training and follow appropriate guidance, policies and procedures.

The provider also SHOULD**:**

- Ensure that all staff who undertake chaperone duties are aware of their roles and responsibilities and are subject to risk assessments and /or security checks.
- Ensure that staff are aware of how and when to report safeguarding concerns to external agencies.
- Ensure that detailed records are maintained in respect of cleaning carried out and audits are carried out to test the effectiveness of infection control procedures.
- Review the arrangements for promoting access and assistance for patients with mobility or other physical disabilities.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses within the practice. Some staff were unaware of the procedures for reporting concerns to external agencies such as the local safeguarding team.

There were systems in place for acting on safety alerts and for sharing information with members of the staff team. Safety incidents and other incidents where things went wrong or near misses were investigated. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients and staff were not always identified or managed. Risk assessments did not identify all risks and were not reviewed to ensure that appropriate actions had been taken to address safety issues. Infection control procedures were not audited minimise risks. Improvements were needed to ensure that staff were trained and understood the practice policies and procedures in relation to safety.

Medicines were not consistently stored, handled and administered safely in line with current guidelines and legislation. Appropriate checks were not carried out consistently and the arrangements for handling medicines were not audited or monitored.

Staff were recruited robustly and there were enough staff deployed to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data made available to us including comparisons to other GP surgeries within the area showed that patient outcomes were at or above average for the locality in relation to assessing and treating patients with long term conditions, vaccination and screening programmes.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely to plan patient care and treatment. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice regularly monitored patients with one or more long term condition and provided advice and guidance to promote good health.

Staff had received training appropriate to their roles and any further training needs had been identified and suitable training and staff development was planned to meet these needs. There was evidence

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of appraisals and personal development plans for staff. The practice staff worked with multidisciplinary teams including community nurses, health visitors and social workers to improve outcomes for patients and ensure that they received coordinated care and support as needed.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in the area for several aspects of care. Patients who participated in the national GP survey in 2014 rated the practice highly for how they were treated by GPs and nurses, their involvement in their care and treatment and being listened to.

Patients we spoke with during the inspection 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. Patients whose first language was not English had access to language interpretation services to help them in understanding information about their care and treatment.

We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided advice, support and information to patients, such as those with learning disabilities, mental health conditions and those with long term conditions.

The practice considered the needs of patients and their families when patients were receiving palliative care and nearing their end of their life. There were procedures in place to identify and act on patients' wishes and the practice worked proactively with other health care providers including community teams and the out-of-hours providers to enable patients to remain at home should they wish. The practice provided information, support and advice to families following bereavement.

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 tailored its appointment systems to meet these needs. The practice recognised the challenges faced by working aged and recently retired people in obtaining appointments and had provided telephone consultations with the duty doctor each day after morning surgery. The practice was planning on providing appointments on Saturdays starting in October 2015.

The practice engaged with patients and the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to

Summary of findings

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 good facilities and was well equipped to treat patients. Some improvements were needed to support patients who may have difficulties in accessing the practice. For example, the door was not automated and patients in wheelchairs may find it difficult to open the door. Also the disabled access toilets did not have a call bell to alert staff in the event of an emergency. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy to meet the individual needs of patients taking into consideration the health care needs of the local population. Staff and patients were aware of and were able to contribute to the practice values and visions. Staff we spoke with were clear about 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 underpin and govern its activity and these were kept under review. Regular meetings were held with clinical and non-clinical staff to review, monitor and improve performance and outcomes for patients.

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 practice had an active patient participation group (PPG) and two members of the group who we spoke with reported that the practice was open and proactive in dealing with comments and suggestions made by patients. Staff were supported to undertake their various roles within the practice and had received inductions, regular performance reviews and 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

This practice is rated as good for the care of older people. Patients over the age of 75 years had a named accountable GP who was responsible for their care and treatment. The practice identified patients who were at risk of avoidable unplanned hospital admissions. These patients were included on the practice's 'unplanned admissions avoidance' list to alert staff to patients who may be more vulnerable. Regular multidisciplinary team meetings were held with other health and social care professionals to support patients and ensure that they received coordinated care and treatment.

The GPs carried out visits to patient's homes if they were unable to travel to the practice for appointments. The practice provided a range of health checks for patients aged 75 years and over. Seasonal flu vaccination and shingles vaccination programmes were provided and the practice was performing well in ensuring that patients received these.

Longer appointments were available if needed. The practice also provided medicines dispensing services to patients who were unable to obtain medicines easily at a pharmacy.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual and half yearly reviews of their health and medication to ensure that their treatment remained effective. Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. 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.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be in person or by telephone. Appointments could be booked up to six weeks in advance and walk-in appointments were available between 9am and 10.30am each day at the practice branch surgery. The practice also provided telephone triage consultations daily.

Information and advice was available to promote health to women before, during and after pregnancy. A full range of pre-conception, antenatal and postnatal care services was available. The practice monitored the physical and developmental progress of babies and young children. Appointments were made available outside of school hours wherever possible.

There were arrangements for identifying and monitoring children who were at risk of abuse or neglect. Records showed that looked after children (such as those in foster care / under the care of the Local Authority), those subject to child protection orders and children living in disadvantaged circumstances were discussed, including any issues shared and followed up at weekly GP meetings and monthly multi-disciplinary meetings. GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments could be in person or by telephone. Appointments could be booked up to six weeks in advance and walk-in appointments were available between 9am and 10.30 am each day at the practice branch surgery. The practice also provided telephone triage consultations daily.

Summary of findings

Information about five yearly health checks for patients aged between 40 and 75 years was available within the practice and on their website. Nurse led clinics were provided for well patient health checks. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the various vaccinations available including diphtheria, tetanus, polio and hepatitis A was available on the practice website. When patients required referral to specialist services, including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice recognised the needs of people who were vulnerable such as patients from travelling communities, those with depression, alcohol or substance misuse issues, people with mental health conditions and those with learning disabilities.

All patients with learning disabilities were invited to attend for an annual health check and staff worked proactively to improve the uptake of these checks.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations such as MIND. Staff knew how to recognise signs of abuse in vulnerable adults and children. Some staff had not undertaken safeguarding training and were not aware of their responsibilities to report safeguarding concerns to local agencies where this was required.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams to support people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

Summary of findings

The practice had suitable processes for referring patients to appropriate services such as psychiatry and counselling, including The Improving Access to Psychological Therapies (IAPT) and referrals to Child and Adolescent Mental Health Services (CAMHS) as required.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. Patients were referred to local counselling sessions where appropriate and patients were provided with information on how to self-refer should they wish to receive counselling.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by reviewing data available from NHS Choices and the national GP patient survey. Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution among patients in order to obtain their views about the practice and the service they received.

We reviewed the findings of the NHS England National Patient Survey 2014. The practice performed in line with or above average within their Clinical Commissioning Group in relation to patients' satisfaction. Patients expressed satisfaction with many aspects of the service they received including access to appointments, trust in GPs and nurses, feeling listened to and being involved in making decisions about their treatment.

We received 19 completed 'Tell us about your care' comment cards. All of patients who completed these expressed satisfaction with the care and treatments and service they received. They commented that staff were polite, kind, caring and helpful. The overwhelming majority of patients told us that they were happy with access to the practice and the appointments system. A number of patients said that they could access same day appointments. A small number of patients commented about waiting times and said that they sometimes waited 15 minutes or more after their appointment time to see their GP.

We also spoke with five patients on the day of our inspection, two of whom was involved with the practice Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with empathy and with respect and the GPs, nurses and other staff were professional, kind, sensitive and helpful.

Areas for improvement

Action the service MUST take to improve

- Ensure that patients are protected against the risks of unsafe care by the safe management of medicines and ensuring that staff receive appropriate training and follow appropriate guidance, policies and procedures.

Action the service SHOULD take to improve

- Ensure that all staff who undertake chaperone duties are aware of their roles and responsibilities and are subject to risk assessments and /or security checks.
- Ensure that staff are aware of how and when to report safeguarding concerns to external agencies.
- Ensure that detailed records are maintained in respect of cleaning carried out and audits are carried out to test the effectiveness of infection control procedures.

Review the arrangements for promoting access and assistance for patients with mobility or other physical disabilities.

The Orsett Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a practice manager specialist advisor and a practice nurse specialist advisor.

Background to The Orsett Surgery

The Orsett Surgery is located in the village of Orsett in Thurrock, Essex. The practice provides services for approximately 7,500 patients living within the areas covering Grays, Horndon, Chadwell St Mary and West Tilbury. The practice has a branch surgery located at 1 King Edward Drive, Grays, Essex RM16 2GG. The branch location was not visited as part of this inspection.

The rate of unemployment and economic deprivation within the area is lower than national averages; there are some pockets of deprivation. The area has a similar breakdown of population by age range with a slightly higher than the national average of people over the age of 75 years.

The practice is managed by four GP partners who hold financial and managerial responsibility for the practice. The practice employs one salaried GP, two practice nurses, a practice manager, and a team of administrative, secretarial and reception staff who support the practice.

The Orsett Surgery is a training practice and two of the partners are trainers to GP registrars, doctors who have completed their medical training and are training to become GPs.

The practice is open between 8.30am and 6.30pm on weekdays with surgeries running from 8.30am to 11.30pm and 4.30pm to 6.30pm daily. The branch surgery is open between 9am to 1pm daily with walk –in GP consultations available between 9am and 10.30am. The practice offered a dispensing service and the dispensary was open for prescription collections from 9am to 2pm and 4pm to 6.45pm

Unscheduled out-of-hours services are provided by South Essex Emergency Doctors Service (SEEDS). Details of how to access out-of-hours emergency and non-emergency treatment and advice were available within the practice and on its website. Patients who telephoned the practice outside of the surgery opening hours are automatically directed SEEDS. There was also information about the range of services available when the surgery was closed including emergency 999 services, the walk-in centre in Grays Town and the NHS 111 service.

Why we carried out this inspection

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

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England and the local Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 14 May 2015. During our visit we spoke with a range of staff including GP's, practice nurses, practice manager, dispensary staff, reception and administrative staff. We reviewed policies, procedures and other documents in relation to the management and day-to-day running of the practice. We spoke with patients who used the service. We talked with carers and family members. We reviewed comment cards, NHS Choices and national GP patient survey results where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that they were supported to raise concerns and that the procedures within the practice worked well.

There were systems for dealing with the alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA). These alerts have safety and risk information regarding medication and equipment, often resulting in the review of patients prescribed medicines and/or the withdrawal of medication from use and return to the manufacturer. The practice manager told us that MHRA and other relevant alerts were forwarded to GP partners for review and that these were then shared with staff through the practice electronic system. Records showed that if the alert related to a specific medication or treatment, GP's reviewed patient and checked the appropriateness of the treatments and risks. GPs amended patient's treatment and substituted medicines with alternatives where this was indicated.

There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. We saw evidence that these were shared with staff and actions taken as necessary to improve safety outcomes for patients.

Complaints, accidents and other incidents such as significant events and near misses were reviewed at the weekly Monday staff meetings to monitor the practice's safety record and to take action to improve on this where appropriate. We reviewed safety records, incident reports and minutes of meetings where these had been discussed during the last three months. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents, accidents and near misses. Staff we spoke with said that they would record, and report any significant or untoward event to their line manager. We saw that reporting forms were available on the computerised system and hard copies were also available and staff were aware of where to find these. We looked at records in respect of incidents, which had occurred within the previous twelve months. Incidents were discussed at weekly clinical staff meetings and we found that these had been investigated and learning or changes to practice had been shared with staff.

Staff, including receptionists, administrators and nursing staff, told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

Reliable safety systems and processes including safeguarding

The practice had policies and procedures in place to manage and review risks to vulnerable children, young people and adults. These included contact details for the local safeguarding teams. Patients who we spoke with during our inspection and those who completed comment cards told us that they felt safe and that they had no concerns. We looked at training records which showed that all staff had received relevant role specific training on safeguarding adults and children. Staff we spoke with knew how to recognise signs of potential abuse or neglect in older people, vulnerable adults and children. From a sample of practice meetings we saw that safeguarding procedures were regularly discussed and reinforced.

The senior GP partner took the lead in safeguarding for adults and children. Records we viewed showed that they had been trained to the appropriate level in safeguarding children. 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. Reception staff we spoke with were unaware of their responsibilities to report concerns to relevant external agencies should this be appropriate.

There was a system to highlight vulnerable patients on the practice's electronic records. GPs were appropriately using the required codes on their electronic case management

system to ensure risks to vulnerable adults and children and young people who were looked after (under the care of the local authority / in foster care) or on child protection plans were clearly flagged and reviewed. Information in relation to risks and vulnerabilities was recorded within the practice computerised system and used to make staff aware of any relevant issues when patients attended (or failed to attend) appointments.

The practice had a chaperone policy, which was available and easily visible in the waiting room and consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice manager told us that where possible chaperone duties were carried out by nursing staff and only where this was not possible that reception staff would perform these roles. Staff we spoke with told us that they had recently received in-house training in chaperone duties Records we viewed showed that staff security checks had been carried out through the Disclosure and Barring Service (DBS) for clinical staff only. Staff we spoke with had a basic awareness of their responsibilities when acting as chaperones; however not all staff could demonstrate that they fully understood their role during an examination, such as observing any examinations or procedures carried out.

Patients' individual records were kept on the practice electronic system which collated all communications about the patient including scanned copies of communications from hospitals, out-of-hours providers and community services. There were procedures in place for dealing with correspondence received and shared so that patient records were accurate and up to date with relevant information about their care and treatment.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice did not have a 'cold chain' procedure around the receipt and prompt storage of medicines, which require refrigeration. Staff told us that when medicines such as vaccines were received that they were stored in medicine fridges immediately. We saw records that showed the temperatures of fridges used to store medicines were checked and recorded daily. However only the actual temperature was recorded. The minimum and maximum temperature over a 24 hour period was not recorded to help identify any issues and to ensure that medicines did not exceed those recommended by the medicine manufacturer.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

The practice had policies in place to check medicines were within their expiry date and suitable for use. The practice held stocks of controlled drugs, which require additional storage and checking procedures. Staff told us that these medicines were not routinely checked and that checks were only carried out at the point at which they were taken for use. Records showed that other medicines were checked regularly. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice provided medicines dispensing services to assist patients who may have difficulties obtaining medicines from a pharmacy. The dispensary area was small, cramped and cluttered. There were no arrangements for checking the temperature of the room to ensure that medicines were not exposed to temperatures in excess of 25 degrees.

Records we viewed showed that dispensing staff had undertaken appropriate training and competencies assessments. Dispensing staff we spoke with told us that they were unfamiliar with the standard operating procedures for dispensing medicines. They showed us a copy of these procedures which had been written some days before our inspection visit. Standard operating procedures are designed to ensure that medicines are labelled and dispensed safely and consistently.

Staff we spoke with confirmed that all prescriptions were reviewed and signed by a GP before they were given to the patient. However, we staff confirmed that there were no arrangements for auditing or checking prescription blank prescription forms to ensure that they were accounted for and handled safely.

The GPs discussed the arrangements for the management of high risk medicines which may have serious side-effects.

Requires improvement

Are services safe?

GPs told us that patients who were prescribed these medicines had regular blood tests carried out and that these were reviewed when authorising repeat prescriptions.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and that when their prescriptions were reviewed and any changes were explained fully. Patients we spoke with and those who completed comment cards told us that that the repeat prescription service generally worked well and they had their medicines in good time.

Cleanliness & Infection Control

The practice had policies and procedures in place to protect patients and staff against the risk of infections. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. Staff we spoke with were aware of these procedures and told us that they were provided with appropriate personal protective equipment including disposable gloves and aprons.

Patients we spoke with during the inspection told us that they found the practice was always clean and that they had no concerns. We observed the premises to be clean and tidy. Hand sanitising gels were available at the reception for patient use. Hand washing sinks with liquid soap and paper towel dispensers were available in treatment rooms and toilet facilities, as were posters displayed describing hand hygiene techniques. Spillage kits were available for cleaning and disposing of body fluids. We saw records to confirm that disposable patient privacy curtains were changed on a regular basis.

The practice provided minor surgical procedures such as excision and biopsy of skin lesions and joint injections. We saw that single use disposable instruments were provided for all minor operations they performed to minimise the risks of infections. We saw that audits were carried out in respect of surgical procedures that were performed in line with policies and procedures.

We saw that the practice had arrangements to segregate and safely store clinical waste at the point of generation until it was disposed of. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles. These were suitably located, labelled and not overfilled.

The practice employed a cleaner and we saw there were cleaning schedules in place for daily, weekly and periodic cleaning tasks for general and clinical areas. Nursing staff undertook cleaning of clinical areas. Cleaning records were kept to show when cleaning had been carried out. Records indicated that cleaning was completed but did not include details of the areas or equipment cleaned. The practice manager told us that they and staff carried out visual checks on the cleanliness of the premises and reported any issues to the cleaning company through the use of a communications book. The cleaners then recorded in this book when action had been taken to address these areas. There were no audits carried out to test the effectiveness of the infection prevention and control procedures in the practice.

The practice nurse took a lead role for infection control. From records viewed we saw that they had undertaken further training to enable them monitor and oversee the infection control procedures within the practice. Records showed that all clinical staff had received infection control training and underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. Non-clinical staff had not received infection control training.

Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. Advice and information was provided so as to help patients protect themselves against the risks of infections. Information and advice was available about the Ebola virus and what they should do should they or someone they knew experienced potential symptoms of the virus.

The practice had conducted a risk assessment to identify and manage the risks associated with legionella (a germ found in the environment which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of diagnostic and screening procedures, such as

blood tests, respiratory, diabetes and well person procedures. Staff 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. Records we viewed showed that relevant equipment such as weighing scales, spirometer, thermometers, ear syringe and the fridge thermometer were calibrated in line with the manufacturer's instructions so as to ensure that this equipment was fit for use. Through discussion with staff and a review of records we saw that equipment was replaced as needed.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. These set out the processes for assessing a person's suitability to work within the practice, including carrying out criminal records checks and obtaining employment references. We reviewed four staff records for staff including dispensary staff, nurses and administrative staff. Records included proof of identification and evidence of each person's qualifications and registration with the appropriate professional body, such as the Nursing and Midwifery Council (NMC) for nurses and the General Medical Council (GMC) for GPs where appropriate. We saw that appropriate references had been obtained for all staff. Criminal records checks through the Disclosure and Barring Service (DBS) had been carried out for all clinical staff. These had not been carried out for administrative or reception staff and the practice manager told us that a risk assessment would be conducted to identify if these were needed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The senior partner told us that there was a low turnover of staff, which helped the practice with continuity of care. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Locum nurses were employed to cover planned absence such as maternity leave and there were also arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and to cover for periods of unplanned absence due to illness.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements and that these were regularly reviewed to ensure that they met the needs of patients.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, which staff were aware of. We saw that a basic risk assessment had been carried out in July 2012. This assessment identified risks relating to the security of records and the premises and there were actions in place to minimise these. The assessment had not been reviewed. During our inspection we observed risks which had not been identified including the storage of cleaning materials in the boiler room and the storage of paper medical records in a room with no smoke detector, despite potentially presenting a fire safety risk.

The practice had policies and procedures in place for recognising and responding to risks in relation to patient safety. Staff we spoke with told us that they were aware of these procedures. For example staff had access to policies and procedures for treating sudden deterioration in patients including children and treating patients in the event of a mental health crisis. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis. We saw that a number of patient records were stored adjacent to the dispensary in an area with no smoke detector. The practice manager told us that a dedicated room had been identified for the secure storage of these records.

GPs we spoke with could demonstrate that they had considered the risks associated with medicines prescribed in the treatment of patients including those who had mental health conditions. We saw that the practice had appropriate systems in place for reviewing patients' medicines every six months or more frequently if required.

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 medicines and equipment was available including access to oxygen and an automated external defibrillator (used to attempt to

restart a person's heart in an emergency). When asked, all members of staff knew the location of this equipment. Staff told us that this equipment was checked regularly. However records were not kept in respect of these checks. There were protocols in place for dealing with medical emergencies including the treatment of cardiac arrest, anaphylaxis and hypoglycaemia and appropriate medicines were available. Anaphylaxis kits were available to treat patients in the event of allergic reaction to medicines. Staff were able to describe how they would act in the event of patients requiring emergency treatment and how they supported these patients.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as loss of power, adverse weather conditions, staff shortages or other circumstances that may affect access to the building or a disruption of the service. The plan was available in a folder at reception and at various points throughout the practice and included details of what actions to take in the event of any disruption such as utilising the branch surgery to treat patients in the event of the main premises being inaccessible. Staff we spoke with were aware of the plan and who to contact should the need arise. We saw that the plan contained relevant details and contact numbers to assist staff.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Fire safety procedures and the evacuation plans were displayed throughout the practice. Records showed that staff had not undertaken fire safety training and the practice manager told us that updates were planned for staff in the near future. Records showed that fire equipment was inspected periodically to ensure that it was in safe working order. Fire evacuation procedures were displayed throughout the practice and staff were aware of the procedures to evacuate the premises in the event of a fire or other incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patient care and treatment was delivered in line with recognised best practice standards and guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to patient care and treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), Clinical Commissioning Group guidelines and policies. Staff told us that information and any changes in legislation or national guidelines were shared during regular clinical staff meetings. Records we viewed confirmed this. Data we reviewed showed that the practice's performance in assessing and treating patients with long term conditions such as diabetes, asthma, chronic respiratory diseases and heart disease were generally in line with or above that the local Clinical Commissioning Group (CCG) and national averages. The practice was also performing well for the uptake of all childhood vaccinations and immunisations, flu vaccinations and women's cervical screening.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs, in line with NICE guidelines and these were reviewed when appropriate. We saw that all patients received appropriate treatment and regular review of their condition. The practice used computerised tools to identify and review registers of patients with complex needs, for example, patients with learning disabilities or those with long term conditions. The senior GP partner and one of the practice nurses had advanced training in treating patients with diabetes.

Clinical staff we spoke with told us that there was a very open culture within the practice for seeking advice and support from colleagues.

Staff told us that information relating to patients who accessed the out-of-hours services and patients' test results were reviewed by GPs on a daily basis. We saw evidence that when patients were discharged from hospital, their patient records were sent to the patient's GP for review and that any changes to medication or ongoing treatments were recorded appropriately.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, summarising patient's records, managing child and adult protection alerts and medicines management.

The practice participated in all the enhanced services from the Clinical Commissioning Group (CCG), Public Health and NHS England. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice achieved high scores in Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed in line with other practices for the majority of areas of monitoring and review of patient.

The practice scored below national averages in the review of patients with diabetes. For example, the practice percentage of patients with diabetes who had a creatinine : albumin ratio test within the previous 12 months was 64% in comparison to the national average which was 86% for the same period. Similarly the practice scored lower than the national averages for patients with diabetes having their blood pressure and cholesterol levels checked within the previous 12 months. These checks help to identify conditions associated with diabetes including kidney disease and heart disease. The senior GP partner attributed these low results to patients failing to attend health reviews and staff were proactively contacting patients to encourage attendance. Data we reviewed showed that the practice prescribing medicines including antibiotics, non- steroidal anti-inflammatory medicines and antidepressants were similar to other practices nationally.

The practice had a system in place for carrying out clinical audits, a process by which practices can demonstrate ongoing quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. We saw that the practice had carried out audits to review their prescribing of medicines including antibiotics and medicines to treat erectile dysfunction to ensure that prescribing practices were safe, in line with local guidelines and followed the National Institute for Health and Care

Good

Are services effective?

(for example, treatment is effective)

Excellence (NICE) guidelines. We saw that where changes to a patient's medicine had been made following reviews or audits that these were communicated with reasons for the changes explained. The practice had also carried out audits in relation to minor surgical procedures carried out to identify and minimise risks of post procedure infections.

The practice protocol for repeat prescribing was in line with national guidance and staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also monitored the routine health checks carried out for patients with long-term conditions such as diabetes, asthma and chronic heart disease and for patients with learning disabilities and those with mental health conditions.

The practice kept a register of patients receiving palliative care. The practice held regular multidisciplinary meetings which were well attended by external professionals such as the community nursing team to help ensure that patients with life limiting conditions were treated and supported appropriately.

Effective staffing

Records we viewed showed that appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. Records we viewed showed that non-clinical staff were not up to date or had not undertaken training including fire safety, infection control and training around the Mental Capacity Act 2005. All staff undertook annual appraisals of their performance from which learning and development needs were identified. Records viewed showed that staff did not have personal development plans in place, which would identify training needs and a plan to meet these.

Records showed that nursing staff had undertaken a range of training courses in relation to their roles including tissue viability, cytology, dementia awareness, diabetes management and administration of immunisations and vaccines. Dispensing staff had undertaken relevant training and completed dispensing services quality competencies.

All GPs were up to date with their yearly continuing professional development requirements and all had either completed their revalidation or had a date set 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). The practice had systems in place for identifying and managing staff performance and providing support and further training to assist staff should they fail to meet expected standards.

Working with colleagues and other services

The practice worked with other service providers, including social services, the local hospital trust and community services to meet patients' needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held quarterly multidisciplinary team meetings to which the relevant community health and social care professionals were invited to review and plan care and treatment for patients such as those who with life limiting illnesses and vulnerable patients. Staff felt that these meetings and the use of the electronic patient recorded system worked well to maintain a comprehensive record of health interventions. The practice had an established system for patient referral to external services for assessments, treatment or advice. Staff reported that they worked well with the local out-of-hours provider to share up to date information in relation to the needs of people who were receiving palliative care was shared so as to ensure that these patients received appropriate care according to their changing needs.

The practice manager and GPs also engaged with other locality managers through meetings for support and advice on issues relating to primary medical services.

Information Sharing

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

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, the community nursing team and health visitors had access to the patient records where patients had consented to the sharing of their medical information. Electronic systems were also in place for making referrals to secondary care services such as specialist consultants. Staff reported that the systems were easy to use.

The practice had ensured the electronic Summary Care Records were completed and accessible on line. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or outside of normal hours.

Consent to care and treatment

The practice had policies and procedures in place for obtaining a patient's consent to care and treatment where patients were able to give this. The policy covered documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent procedures included information about people's right to withdraw consent.

GPs and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patient's consent before carrying out physical examinations or providing treatments. Patients we spoke with confirmed that their treatment, options available, risks and benefits had been explained to them in a way that they could understand. They told us that their consent to treatment was sought before the treatment commenced.

Clinical staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties to meet the requirements of these legislations when treating patients. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia who were supported to make decisions through the use of care plans, which they and / or their carers were involved in agreeing, where they were able to do so. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room where patients could see them. These included information to promote good physical and mental health and lifestyle choices. Information available included advice on diet, smoking cessation, alcohol consumption and substance misuse. There was information available about the local and national help, support and advice services. This information was available in written formats within the practice and links to useful information was available on the practice website.

Information about the range of immunisation and vaccination programmes for children and adults, including MMR, Shingles and a range of travel vaccinations were well signposted throughout the practice and on the website.

The practice offered a full range of health checks. All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice had identified and offered appropriate smoking cessation support to patients.

Data we viewed for 2013/14 showed that the practice performed at or above the local and national averages for the uptake of standard childhood immunisations, seasonal flu vaccinations, cervical screening (smear tests) and annual health checks for patients with one or more long-term health condition such as diabetes and respiratory diseases. At the time of our visit we saw that the practice was monitoring its performance for 2014/15 and were proactively targeting patients who had failed to attend appointments for healthcare screening, immunisations and annual health checks.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with during our inspection commented that all staff were kind, caring and that staff listened to them. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National GP Patient Survey, and a survey of patients undertaken by the practice between 27 December 2014 and 25 January 2015. We saw that patients responded positively indicating that they received a caring service. For example, 91% of patients who completed the national GP patient survey said that the last GP or nurse who were good at treating them with care and concern. This was higher than both the local Clinical Commissioning Group average (79%) and the national average (85%). The results from the practice survey were also positive with patients reporting that all staff were helpful and caring and comments reflecting that GPs and nurses were explained care and treatment in a way that patients could easily understand.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards and all were positive about the care they received and how they were treated by staff. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring, kind and compassionate. 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. Privacy 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 waiting area was open plan and staff were careful not to repeat personal information when speaking with patients on the telephone. Private facilities were available to speak with patients away from the public reception area to maintain patient confidentiality. We also saw that there were arrangements in place for the secure disposal of confidential records and information through a commissioned service.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was a policy and procedure in place to support and manage patients who displayed abusive behaviour. Staff told us how they would try to immediately diffuse the situation and accommodate patients' needs wherever possible.

Care planning and involvement in decisions about care and treatment

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

We reviewed information from the 2014 National GP Patient Survey. This showed the practice performed above the local Clinical Commissioning Group (CCG) average for patient's satisfaction in relation to their involvement in their care and treatment. 83% of patients who responded to the survey said that GPs and nurses were involving them in decisions about their care. The local CCG average was 76%. The practice also scored above the local national averages for satisfaction around GPs and nurses being good at listening to patients and giving them enough time during consultations.

The practice had considered the needs of the local population group and had identified patients from ethnic minorities and those whose first language was not English. The majority (94%) of patients spoke English as their first language. Staff told us that language interpretation services were available and they knew how to access these.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Patients who we spoke with during the inspection told us that staff were caring and that they offered emotional support as needed. We saw that the practice worked proactively with other health and social care providers to enable patients who wished to remain living in their homes when their health deteriorated. GPs and community staff told us that they worked well to support patients' changing needs in relation to end of life care and treatment and that supporting patients to stay in their preferred place. We saw that patients receiving palliative care had care plans, which were shared with relevant health care providers, including the out-of-hours service to ensure that patients received appropriate care as they approached their end of life. The practice had procedures for supporting bereaved families. Staff told us that if families had experienced bereavement, their usual GP contacted them by telephone and appointments or home visits were arranged as needed.

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified at registration we were shown the written information available for carers to ensure they understood the various avenues of support available to them. The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Information in the patient waiting room, told patients how to access a number of support groups and organisations within the local area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice recognised the challenges in responding to the needs of patients from the working age and recently retired population group, including patients who commuted into work. In order to help meet these needs the practice had introduced a telephone consultation surgery with the duty doctor, which was provided daily after morning surgery. The practice was planning on offering Saturday morning appointments via a shared hub from October 2015.

The practice kept registers for patients who had specific needs including vulnerable people, patients with dementia, mental health conditions, learning disabilities or life limiting conditions who were receiving palliative care and treatment. These registers were used during the regular multidisciplinary meetings to discuss, monitor and respond to the changing needs of patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Medicine dispensing services were provided to assist patients who may find it difficult to access a pharmacy. Home visits available on a daily basis for patients who were unable to attend the practice and where possible these visits were carried out by the patients GP.

The practice kept registers of patients with learning disabilities and those with mental health conditions and worked proactively to ensure that patients received an annual physical health check and medication reviews. Weekly visits were made to the local care home which accommodated approximately 50 patients.

The practice had policies and procedures for promoting diversity and equality. The majority of patients at the practice spoke English as their first language. The practice had access to translation services if required and two members of staff could communicate using sign language.

The practice had reviewed the facilities to meet the needs of patient with disabilities and provided step-free access to the building. However, the practice did not have an automated door opening system or bell system to alert staff if a patient had difficulty gaining access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The accessible toilets did not have a call bell which staff could use to alert staff in case of an emergency. The practice did not have a hearing loop.

Access to the service

Patients we spoke with during the inspection and those who completed comment cards told us that they could usually get an appointment with their preferred GP and same day appointments for urgent treatments if needed. These levels of patient satisfaction were also reflected in the results of the National GP Patient Survey 2014. We saw that 73% of patients who responded to the survey said that their overall experience of making an appointment was good. 89% of patients said that their last appointment was convenient and 83% aid that they were able to get an appointment or speak to a GP the last time they tried. 93% said that they found it easy to get through to the surgery by telephone and 93% of patients rated their overall experience of the practice appointments system as good. These results were in line with or above the local Clinical Commissioning Group (CCG) and national averages for patient satisfaction.

GP appointments at the main branch were available from 9am to 11.30am and 4.30pm to 6.30pm on weekdays. Pre-booked and on the day appointments were available each day. Walk-in GP and booked nurse appointments were available at the practice branch surgery on a daily basis. Details about how to make, reschedule and cancel appointments was available to patients on the practice website. This included how to arrange urgent appointments and home visits and how to book and cancel appointments through the website. Booked GP appointments could be made up to six weeks in advance and nurse appointments up to four weeks in advance.

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 they were transferred directly to the out-of-hours service.

GPs and reception staff told us that appointments for children and young people were available outside of

Good

Are services responsive to people's needs?

(for example, to feedback?)

school hours and home visits were available for older people and those with long term conditions, who were unable to visit the practice. Longer appointments were available as needed for patients who required more time or support including people with learning disabilities, those with mental health conditions and patients with complex medical conditions.

The practice offered a range of services including weekly diabetes clinics at the main surgery and nurse led appointments for annual and new patient health checks, immunisations and vaccinations for adults and children, smoking cessation, contraceptive device and implant fittings, sexual health advice post natal and baby checks.

Listening and learning from concerns & complaints

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

We saw that information was available to help patients understand the complaints system, in posters displayed in patients waiting areas and within a practice complaints leaflet. 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 sample of complaints received by the practice within the previous 12 months. We found that the patients concerns had been fully investigated and a response was sent to the patient, outlining the outcome of the investigation and offering apologies where this was indicated. We saw that complaints had been investigated and responded to within the timescales as set out in the complaints procedure. The response letters also included details of how a complainant could escalate their concerns to the NHS England and the Health Services Ombudsman, should they remain dissatisfied with the outcome or if they felt that their complaints had not been dealt with fairly.

From records we viewed and through discussions with several members of staff we found that patient's complaints and concerns were discussed at staff meetings, where learning and changes to practices were shared. Staff we spoke with told us that they were able to contribute ideas and suggestions for improving practice where things went wrong. We saw that complaints and concerns were reviewed periodically to identify any themes or trends in patient dissatisfaction.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver and maintain high quality general medical services and to meet the individual needs of patients. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these. The practice had systems for discussing and reviewing future planning and strategy, taking into account developments and changes in the local population. These discussions were held through clinical and non-clinical staff meetings and engagement with the local Clinical Commissioning Group.

Governance Arrangements

The practice had a number of policies and procedures in place to govern its activity and these were available to staff. We looked at a sample of these policies and procedures, including those related to safeguarding adults and children, medicines management, infection control, staff recruitment and training, fire safety and patient confidentiality. All policies we viewed were up to date and subject to regular review to ensure that they were relevant and developed with local and national guidelines. Staff we spoke with said that they had access to and understood the policies and how they related to their various roles within the practice.

There was a clear leadership structure with named members of staff in lead roles. Staff we spoke with said that they were supported and there were dedicated staff with lead roles such as infection control, complaints, safeguarding and medicines management. GPs also took lead roles in learning disabilities, mental health and dementia.

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

A number of clinical audit cycles were carried out in the practice. Audits were carried out following alerts and safety information about medicines. Patients were reviewed and medicines discontinued or alternatives prescribed where this was indicated. We saw that an audit had been conducted around minor surgical procedures carried out at the practice. A number of changes were implemented as a result of the initial audit findings and the audit was repeated and showed that the changes had resulted in a reduction in the number of post-surgery complications such as infections.

From a review of records including minutes from staff meetings, appraisals, complaints and significant event recording we saw that information was regularly reviewed to identify areas for improvement.

Leadership, openness and transparency

All staff we spoke with told us that GPs and the practice management team were supportive and approachable. GPs told us that the senior partner was proactive and they spoke very highly about how they promoted transparency within the practice. All staff we spoke with told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held weekly clinical meetings, six monthly reception and administration staff meetings to discuss any issues or changes within the practice. There were also two practice meetings held each year and the senior GP partner told us that the frequency of these meetings would be increased.

Seeking and acting on feedback from patients, public and staff

The practice sought feedback from patients on a regular basis. The practice had an active Patient Participation Group (PPG) made up of 11 patients who meet with staff twice a year. A PPG is made of practice staff and patients that are representative of the practice population. The aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided and, over time, commissioned by the practice. The practice also had a virtual PPG group made up of 130 patients who contributed to the group through email. This group carried out an annual patient survey and the results of these were made available to patients via the practice website and displayed in the patient waiting area. Following each survey the group developed and action plan describing how improvements would be made.

Are services well-led?

Good

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

We spoke with two members of the PPG and they told us that the practice was open to and acted on, where possible, the suggestions made by the group. They told us about improvements made as a result of the patient survey. This included information about waiting times displayed in the waiting area and plans to introduce electronic prescribing. The PPG had recently produced a newsletter, which was available to patients and provided updates and information about the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they were supported to actively contribute and give their feedback, comments and suggestions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff and those we spoke with said that they would feel confident in reporting any concerns.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff, all of whom confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and improve patients' experiences and to deliver high quality patient care.

Clinical staff told us that the practice supported them to maintain their professional development through training and mentoring. The practice held clinical educational meetings each month and staff had access to 'Time to Learn' sessions each month. All the staff we spoke with told us that the practice was very supportive of training and that they had protected time for learning and personal development. Through discussions with staff and a review of records we saw that the practice monitored, reviewed and acted on incidents such as significant events, near misses and complaints to make improvements as needed

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who used the service and others were not protected from risks associated with medicines as there the arrangements for storing vaccines, recording and monitoring medicines were not robust. Controlled drugs were not checked in line with current requirements. Appropriate checks were not carried out to ensure that medicines were stored at appropriate temperatures. This is a breach of regulation Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Health and Social Care Act (Regulated Activities) Regulations 2010 Safe Care and Treatment.