Marazion 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 comprehensive inspection at Marazion Surgery on 3 March 2015. Overall the practice is rated as good.

We found the practice to be good for providing safe, responsive and effective and well led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people including those recently retired and students, people who were vulnerable and those experiencing poor mental health and those with dementia.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed at team meetings.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- 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. For patients unable to visit the practice nursing staff from the practice delivered care to housebound patients in their homes.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

We saw areas of outstanding practice:

Summary of findings

The practice had reviewed patients taking medicines that were affected by the new law on driving after taking certain medicines. The Drug Driving Specified Limits Amendment Regulations 2015 came into force on 2 March 2015. This new offence covers driving with certain controlled drugs, including some prescription drugs and a number of over the counter medicines, above specified limits. They had written to the patients making sure that they were aware of the new ruling and invited patients to arrange for a telephone consultation if they had any concerns

The practice was accredited with Level 3 EEFO status. EEFO is a word that has been designed by young people, to be owned by young people. EEFO works with other community services to make sure they were young people friendly. Once a service had been EEFO approved it meant that service had met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on the issues young people face to face. Part of this scheme was the use of a green card. This allowed for a young person to be seen on the same day by a GP.

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 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. Medicines were stored, managed and dispensed in line with national guidance. There were safeguards in place to identify children and adults in vulnerable circumstances. There was enough staff to keep people safe. Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data obtained both prior to and during the inspection showed the practice had systems in place to make sure the practice was effectively run. The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. Staff employed at the practice had received appropriate support, training and appraisal. GP appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed and understood the needs of their local population. The practice identified and took action to make

Summary of findings

improvements. Patients reported that they could access the practice when they needed. Patients reported that their care was good and that they were treated with respect. The practice was well equipped to treat patients and meet their needs.

There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver quality care and treatment and they were looking for ways to improve. Staff reported an open culture and said they could communicate with senior staff. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care.

The practice had an active patient participation group (PPG) which was involved in the core decision making processes of the practice.

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 providing care to older people. All patients over 75 years had a named GP. Health checks and promotion were offered to this group of patients. The practice worked with the community matron to keep patients within their own homes. Staff from the practice visited the housebound to ensure tests and routine examinations were carried out. Medicines were delivered to the patient's home or to a nearby shop for ease of access. There were safeguards in place to identify adults in vulnerable circumstances. The practice worked well with external professionals in delivering care to older patients, including end of life care. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people on set days as well as during routine appointments. Staff recognised that some patients required additional help when being referred to other agencies and assisted them with this.

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions. The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes and asthma. Letters were sent to patients to remind them to book appointments for their routine checks. Longer appointments were available for patients if required, such as those with long term conditions. The practice had a carers' register and all carers were offered an appointment for a carers' check with nursing staff. The practice worked with the district nurses to keep patients within their own homes by visiting them and carrying out routine checks.

Families, children and young people

Good

The practice is rated as good for families, children and young people. Families had a named GP. Staff worked well with the midwife to provide antenatal and postnatal care. Postnatal health checks were provided by a GP. The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening. The practice is a member of the EEFO system for young people. Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual

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health screening including chlamydia testing and cervical screening. The GPs training in safeguarding children from abuse was at the required level. Young carers were identified and supported to contact support services.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people. The practice provided appointments on the same day. The practice operated extended opening hours one morning and two evenings a week with the GP and healthcare assistant. Appointments could be booked on line and nurses appointments up to six weeks in advance to allow for flexibility. Smoking cessation appointments were available. The practice website invited all patients aged between 40 years to 75 years to arrange to have a health check with a nurse if they wanted. A cervical screening service was available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at team meetings. Referral to a counselling service was available. The practice did not provide primary care services for patients who are homeless within the village as none were known, however, the practice looked after patients in a homeless hostel in Penzance. Staff said they would not turn away a patient if they needed primary care and could not access it. Patients with interpretation requirements were known to the practice and staff knew how to access these services. Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health, including people with dementia. The practice was aware of their ageing population group. Staff were aware of the safeguarding principles and GPs and nurses had access to safeguarding policies. All staff had received training in the Mental Capacity Act (MCA) 2005 and were aware of the principles and used them when gaining consent. The practice worked closely with the community matron and district nurses to keep patients at home. There was signposting and information available to patients. The practice referred patients who needed mental health services to the community psychiatric

Summary of findings

nurses and GPs kept in regular contact with the patient during a crisis or illness to ensure that they were managing. Support services for patients with depression were provided at the practice, such as counselling. Patients suffering poor mental health were offered annual health checks as recommended by national guidelines.	

Summary of findings

What people who use the service say

We looked at patient experience feedback from the national GP survey from 2014. The patient's survey received 130 responses and showed 91% of patients found that GPs gave them the time they needed with 96% saying that GPs were good at explaining treatment and tests to them. 86% of patients said that the nursing staff were very helpful and explained their treatment well and 96% of the patients found the reception staff helpful.

We spoke with three patients during the inspection and collected 24 completed comment cards which had been left in the reception area for patients to fill in before we visited. All of the comment cards gave positive feedback. Patients told us the staff were friendly, they were treated with respect, their care was very good, and they were always able to get an appointment. The comment cards also told us how they felt listened to by the staff and how supportive staff were.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions from the practice.

Outstanding practice

The practice had reviewed patients taking medicines that were affected by the new law on driving after taking certain medicines. The Drug Driving Specified Limits Amendment Regulations 2015 came into force on 2 March 2015. This new offence covers driving with certain controlled drugs, including some prescription drugs and a number of over the counter medicines, above specified limits. They had written to the patients making sure that they were aware of the new ruling and invited patients to arrange for a telephone consultation if they had any concerns.

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Marazion Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included, a GP specialist advisor a practice manager specialist advisor, and a CQC Pharmacist

Background to Marazion Surgery

The Marazion Surgery provides primary medical services to people living in Marazion and the surrounding areas. This was a comprehensive inspection.

At the time of our inspection there were approximately 7,000 patients registered at the service. The practice had a team of 5 GP partners, two female and three male GPs which equates to four fulltime GPs, and one part time female salaried GP. The partners held managerial and financial responsibility for running the business. There were three nurses and two assistant practitioners at the practice. In addition there was a practice manager, and additional administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors and midwives.

The practice is open between Monday and Friday 8am – 6pm. Early morning appointments were available from 7.40am one day a week and 6.30pm - 8pm one evening a week. These are pre-bookable appointments with a GP or the assistant practitioner and are designed to be used by patients going to work.

The practice also has a dispensary that is open Monday to Friday between 8:30 am to 6pm closing between 1:30pm to 2pm for lunch each day except Wednesdays when it is closed between 1pm and 2pm to allow for staff training.

Outside of these hours patients dial the practice telephone number and obtain instruction on how to contact the GP on call for emergencies. Advice can also be obtained by another health care provider by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to two weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place. Patients could obtain these appointments either by telephoning the practice or on line using the system The Waiting Room.

Why we carried out this inspection

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.

How we carried out this inspection

Before conducting our announced inspection of the Marazion Surgery, we reviewed a range of information we

Detailed findings

held about the service and asked other organisations to share what they knew about the service. Organisations included the local Health watch, NHS England, and the local Cornwall Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on 3 March 2015. We spoke with three patients, six GPs, four of the nursing team and three of the management and administration team. We spoke with representatives of the patient reference group (PRG) and collected 24 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. GPs at the practice met up every Monday to discuss any significant events. Significant event forms were recorded in writing and entered onto a computer system by a medical secretary. Evidence from these forms showed that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that these monthly meetings were well structured, well attended and not hierarchical.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

These alerts were received by the practice manager, who cascaded them to all relevant staff. These had been discussed at team meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff had received on line training in accident and incident reporting. There were records of significant events that had occurred during the last 13 months and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We saw evidence of action taken as a result for example a patient had been given correspondence relating to another patient, the incident had been discussed at staff meetings and a full investigation had taken place. New processes were put in place to prevent further occurrence. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at team 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. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in 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). All nursing staff, including health care assistants, had been trained to be a chaperone. The practice manager had also undertaken training and understood their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the dispensary and found they were stored securely and were only accessible to authorised staff. The temperatures in the medicines refrigerators were monitored to show that these medicines were stored within the recommended ranges; however there were no records of room temperature monitoring kept. Systems were in place to check that medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Systems were in place to deal with any medicines alerts or recalls, and records kept of any actions taken.

There were clear operating procedures in place for dispensary processes. Systems were in place to ensure all acute prescriptions were signed before being handed out to patients, and most repeat prescriptions were also signed before being given out. On occasions, a few medicines may be handed out to patients the day before being signed, however this would only be for medicines within their repeat prescription review date, and if needed urgently before the 48 hour requested ordering time. Dispensary staff showed us the procedure for generating repeat prescriptions, and how the system highlights medicines approaching their review dates and those that have passed this date. High risk medicines needing frequent monitoring were kept separate so that GPs could check that the required tests had been done and were up to date.

Controlled drugs, medicines dispensed into blister packs, and any new medicines were checked for accuracy by a second dispenser, and other medicines were scanned using a barcode system to help reduce any dispensing errors. Any incidents or 'near misses' were recorded, monitored and actions put in place to reduce the risks of any recurrence. The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs, and regular checks of stock levels were undertaken and recorded. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Blank prescription pads and printer forms were held securely in the practice. Records were held of forms ordered and received, and during our inspection systems were set up to record when these forms were taken for use, which enabled an audit trail to be maintained of the whereabouts of these forms.

We saw records showing that dispensary staff had received appropriate training and had regular appraisals of their competence.

The practice had established a home delivery service for patients who were unable to collect their prescriptions from the practice, and three local delivery collection points had been set up to make it easier for patients to collect their medicines. There were clear records kept of these medicines, and systems in place to return and follow up any uncollected items.

Cleanliness and infection control

Patients said the practice was always very clean. There was an infection control policy and a dedicated infection control lead who attended up to date training. Staff were clear about their responsibilities in relation to infection control. For example, all staff knew who the lead for infection control was, knew where to find policies and procedures and were aware of good practice guidance. Nursing staff were responsible for managing clinical spillages and had spillage kits available for use. Infection control audits were undertaken.

The treatment and consulting rooms appeared very clean, tidy and uncluttered. We saw that staff all knew where items were kept and worked in a clean environment. The clinical rooms were stocked with personal protective equipment (PPE) which included a range of disposable gloves, clinical cleaning wipes, aprons and coverings, which

staff used. This reduced the risk of cross infection between patients. Within communal areas, for example the public toilets, hand washing guidance and paper towels were available.

There was an appropriate system for safely handling, storing and disposing of clinical waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its weekly collection from a registered waste disposal company. There were cleaning schedules in place and an infection control audit system in operation. Treatment rooms had hard flooring to simplify the clearance of spillages. Staff had received updated training in infection control.

Equipment

Electrical appliances were portable appliance tested (PAT) to ensure they were safe This was carried out in October 2014. Fire extinguishers were maintained and checked by an external company every year the last check having taken place in July 2014. We saw servicing records for medical equipment were up to date, they are serviced each year and we saw that they had last been calibrated in September 2014. Disposable medical instruments were stored in clinical treatment rooms in hygienic containers ready for use. We found medical equipment and supplies were within their date of expiry.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had assessed the administrative staff as not requiring a DBS check. There was a written risk assessment in place which confirmed this.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff 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.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

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 and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice also had a well stocked accessible first aid kit.

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, and anaphylaxis. 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, 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.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 (NICE) and from local commissioners. Staff said new guidelines were discussed at clinical and management meetings where the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and discussions with specialist health care professionals when appropriate.

The GPs and practice nurses told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and said they received support and advice from each other. The practice has protected weekly meetings. GPs told us this supported all staff to continually review and discuss new best practice guidelines, for example, give feedback from courses attended and discuss recent publications Our review of the clinical meeting minutes confirmed that this happened

The practice had palliative care registers which were discussed with external services to ensure continuity of patient care. The practice had a learning disability register which was kept up to date by checking it with the local social care teams. The practice offered patients with a learning disability an annual review of their care.

Patients who were housebound were offered the same treatments and tests in their homes, for example the practice staff would visit patients and carry out 24 hour testing.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, adult and child protection alerts management and medicines management.

The GPs told us clinical audits were often linked to medicines management information, for example, we saw an audit regarding the prescribing and monitoring of medicines used in inhalers to assist with breathing to ensure that the correct dosage and testing was being given to the patients and that patients were on the correct dosage. The GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question, and where they continued to prescribe it; they had outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a nurse had been funded to complete a degree in chronic disease as well as chronic disease management. A receptionist was fully supported to become a trained assistant practitioner.

The nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. Both the practice nurses had received training for their roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines.

The practice had policies in place to identify and manage poor performance.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice was part of the Living Well scheme and liaised with their co coordinators to assist frail and vulnerable people in their own homes. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff 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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff had received training in and were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice. Staff had accessed MCA training available on the eLearning system used.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal and written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. The nurses obtained signed consent for ear syringing; the consent form listed any complications that occur as well as when the procedure should not be carried out.

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

Good

Are services effective?

(for example, treatment is effective)

understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

There was information on various health conditions and self-care available in the corridor of the practice where they could be looked at in privacy. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care. The practice offered new patients a health check with a nurse or with the GP if a patient was on specific medicines when they joined the practice.

The practice offered patients who were eligible, a yearly flu vaccination. This included older patients, those with a long term medical condition, pregnant women, babies and young children. For patients over the age of 78 years a vaccination against shingles was also available. The practice invited patients to make an appointment for these vaccinations. Patients unable to visit the practice were given the vaccination in their own homes by practice staff.

Patients with long term medical conditions were offered yearly health reviews. Diabetic patients were offered six monthly reviews. All registered patients over 16 years of age could request a consultation even if they have not been seen by their GP within a period of 3 years.

A travel consultation service was available. This included a full risk assessment based on the area of travel and used the 'Fit for travel' website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

The practice was accredited with Level 3 EEFO status. EEFO is a word that has been designed by young people, to be owned by young people. EEFO works with other community services to make sure they were young people friendly. Once a service had been EEFO approved it meant that service had met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on the issues young people face to face. Part of this scheme was the use of a green card. This allowed for a young person to be seen on the same day by a GP.

There was information on external services on sexual health. Young patients are at higher risk of some sexually transmitted infections, particularly chlamydia. Patients could request testing for chlamydia.

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 a national survey performed in January 2014. Evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the patient survey showed the practice was rated high for all outcomes including consideration, reassurance, and confidence in ability and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and all 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. We also spoke with three 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.

The reception front desk was open; however a freestanding sign was in place asking for patients to stand back from the desk to give patients more space and assist with confidentiality. The telephones at the front desk were for making appointments, more confidential matters were dealt with at the back desks which could not be overheard. The practice had a separate window to the right of the main desk where patients could talk more privately with staff if they wished too. A recent patient survey undertaken by the PPG had highlighted the need to make patients more aware of this facility. We saw that notices advising of this service were displayed.

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 96% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results. Both these results were above the average compared to CCG area.

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

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

Patient/carer support to cope emotionally with care and treatment

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

Notices in the patient waiting room, on the TV screen and patient website also directed people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice recognised the needs of the older population living in isolated locations or were unable to leave their homes. These patients received home visits from the GPs and the nurses.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs.

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 patients' 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 practice welcomed feedback from patients and external bodies and used significant events, complaints and near misses to improve the services provided. To obtain additional feedback from patients, a patient's participation group (PPG) undertook surveys and these were to consult about opening times, making routine and urgent appointments, telephone access, environment and the overall opinion of the practice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, to increase patient awareness that they could book appointments online via the practice website using 'The Waiting Room'. The practice had received a good response from patients being able to book appointments on line and was exploring further ways to promote this service on their website and by texting patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team meetings.

The practice had level access for patients using wheelchairs and patients with pushchairs. The front door and corridors were wide and all consultation and treatment rooms were on the same floor level allowing easy access for wheelchair users. Toys were available for younger children. 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 practice had the medical equipment it required to provide the services it offered. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place.

Access to the service

Opening times and out of hours arrangements were displayed on the front door of the practice and in all Practice leaflets and relevant posters, practice website, and on NHS Choices website.

Appointments were available from 8:30 am to 1:30pm and then from 2pm until 6pm. Both the GP and healthcare assistant worked extended hours on two evenings and one morning a week to accommodate patients that had difficulty accessing the practice during the day.

Patients were able to telephone to pre-book an appointment with a GP up to two weeks in advance, and six weeks for nurse and healthcare assistant appointments. Patients could also book an appointment up to two weeks in advance on-line via the practice website using 'The Waiting Room'; which was available twenty four hours a day. Patients were able to telephone the Practice to make an appointment on the day with a GP, Nurse or Health Care Assistant.

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 they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes by a regular GP for those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see

Good

Are services responsive to people's needs?

(for example, to feedback?)

another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and 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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was displayed as well as information about advocacy services. Complaints forms were readily available on the reception desk. 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.

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

Staff were able to describe the vision, values, strategic and operational aims of the practice. Staff said one of the main strengths of the practice was the morale and team atmosphere. There were clear lines of accountability and areas of responsibility. Staff knew what their responsibilities were in relation to these.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its 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 monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example following minor surgery at the practice.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out by an outside provider and where risks were identified and action plans had been produced and implemented.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had an active patient participation group (PPG) The PPG included representatives from various population groups; for example young adults and those recently retired. The PPG met regularly and minutes from their meetings were available in the practice and on their website. We met with three members of this group and they told us of different ways that the practice had acted upon their suggestions**,** for example promoting the area in reception where confidential conversations could be held between patients and staff.

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected time to carry out any learning.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to

Are services well-led?

Good

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

ensure that staff received recognition for the good works they had performed as well as discussion on how the practice improved outcomes for patients. For example a policy was written identifying that all medications being dispensed at the practice should be scanned when printing and attaching labels to patient's medicines as this was a safety check to ensure the correct medicines were dispensed.