Cantilupe 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 inspected this service on 15 October 2014 as part of our new comprehensive inspection programme. Cantilupe Surgery has a branch surgery but we did not inspect this at this time.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw several areas of outstanding practice including:

- The practice nurse was qualified and had trained to provide minor surgery for patients. This was a timely and effective service that ensured treatments were available at the practice and that patients do not have to wait for referral appointments elsewhere.
- There were two nurse consultants at the practice who acted independently to the GPs who prescribed, arranged investigations and referred patients to specialist doctors.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.

Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence that confirmed that these guidelines were influencing and improving practice and outcomes for their patients.

We saw data that showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and its links with other local providers to share best practice. We saw that the practice used a multidisciplinary approach to provide patients with an effective service.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice provided all staff with annual appraisals and personal development plans that staff continued their skill development to ensure patients were provided with up-to-date treatment and care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. Patients told us they were treated with dignity and respect at all times and that they considered the practice to be very caring.

Summary of findings

We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. The practice referred to the Gold Standard Framework in caring for patients nearing the end of their life. This ensured their care was reviewed appropriately and that patients were supported to make decisions about their care and treatment for as long as possible.

We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the 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. The practice had reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. The practice had an effective range of facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

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 this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

Summary of findings

The practice had a number of policies and procedures to govern activity, and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon.

The practice had an active virtual patient participation group (PPG). A virtual PPG is usually patient volunteers who share their views and respond to surveys on the practice's website about the services offered and how improvements can be made to benefit the practice and its patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of the inspection. They included women and men of varying ages and population groups. Patients told us they were extremely satisfied with the service they received at the practice. They could always get an appointment at a time that suited them, including same day appointments. They told us they had confidence in the staff and they were always treated with dignity and respect.

Three patients were mothers with young children. They said they were seen on time or shortly after their appointment time, which they appreciated. They said they were treated with consideration by all staff and that the GPs were very supportive. They said they were given clear information about the matters which concerned them and were fully involved in discussions about treatment for themselves or their children.

Older patients told us they were always able to get appointments as required and that their named GP would visit them at home if they needed this. They described the care and support provided by the practice as exceptional and very caring.

We reviewed the 18 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all comments were extremely positive. Patients told us that staff were always friendly and helpful. They also told us they felt listened to and did not have to wait for appointments.

We looked at the national GP Patient Survey published in July 2014. The survey found that 82% of patients rated Cantilupe Surgery as good or very good, which was among the best in the CCG area. 88% of patients said they would recommend the practice to someone new to the area. 83% of the patients who responded reported that they had had a good experience in making appointments at the practice.

Outstanding practice

- The practice nurse was qualified and had trained to provide minor surgery for patients. This was a timely and effective service that ensured treatments were available at the practice and that patients do not have to wait for referral appointments elsewhere.
- There were two nurse consultants at the practice who acted independently to the GPs who prescribed, arranged investigations and referred patients to specialist doctors.

Cantilupe Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP. The team also included a second CQC inspector and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Cantilupe Surgery

Cantilupe Surgery is located in Hereford and provides primary medical services to patients at both the Hereford surgery and their branch surgery located in Hampton Dene. We did not inspect the branch surgery at Hampton Dene as part of this inspection. The practice area is centered on the east of the City of Hereford and extends out to the east to three rural villages on the perimeter of their boundaries - Hampton Bishop, Lugwardine and Bartestree. There were 11,871 patients registered at the practice at the time of our inspection.

The practice is an approved GP training practice. This means that fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP.

The practice has three male and five female GPs, a practice manager, a deputy practice manager, three nurse practitioners, two practice nurses, two healthcare assistants and reception staff. The practice is open from 8am to 6pm Monday to Friday. The practice offers extended hours on Mondays with a practice nurse, a nurse consultant or a GP from 6.30pm to 8pm.

Hampton Dene branch surgery opens from Monday to Thursday 8.30am until 5pm and closes from 12.45pm to1.45pm. There is also a walk in surgery at Hampton Dene branch surgery every week day from 9am to 10.30am for patients with minor illnesses or new health concerns only. Hampton Dene surgery opens on Fridays from 8.30am to 12.45pm only, and online booking is also available at both surgeries. One GP is available 'on call' each day and has fewer appointments to enable them to deal with urgent enquiries. Home visits are available for patients who are too ill to attend the surgery.

The practice treats patients of all ages and provides a range of medical services. Cantilupe Surgery has a higher percentage of its practice population in the 65 and over age group than the England average.

The practice provides a number of clinics such as asthma, diabetes and healthy heart. It offers child immunisations and minor surgery. The practice has two specialised healthcare assistants (phlebotomist) who collect blood from patients. The practice does not provide an out-of-hours service but has alternative arrangements for patients to be seen when the practice is closed. The practice now offers extended hours appointments for patients at weekends through a government initiative awarded to the county of Herefordshire. An agency provides GP cover for these appointments and these are made available to patients at the practice premises at weekends.

Why we carried out this inspection

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

Detailed findings

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.

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

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

How we carried out this inspection

Before our inspection of Cantilupe Surgery, we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Herefordshire Clinical Commissioning Group (CCG), the NHS England local area team and the Local Medical Committee (LMC) to consider any information they held about the practice. We spoke with the deputy manager of a residential nursing home where patients were registered with the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 15 October 2014. During our inspection we spoke with a range of staff that included five GPs, the practice manager, the deputy practice manager, the nurse practitioner, two nurse consultants, a health care assistant and four reception staff. We also looked at procedures and systems used by the practice.

We spoke with seven patients who visited the practice and observed how staff interacted with them. We reviewed 18 comment cards where patients and members of the public shared their views and experiences of the practice. We also spoke with a member of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services and the quality of care provided.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice had systems in place for reporting and recording incidents or significant events. Significant events (SEs) were prioritised on the basis of their actual or potential consequences for the quality and safety of patient care. We saw records that confirmed this. We spoke with the GPs and staff about these procedures. Staff told us that they were encouraged to record all incidents and events by the GPs and the practice manager. We found there was a clear understanding among staff about safety and learning from these incidents.

Records showed that concerns, near misses, SEs and complaints had been appropriately logged and investigated and that changes had been made to clinical practice. For example, we saw recorded in March 2014, where a patient had suffered a reaction caused by a side effect of the hormone replacement therapy (HRT) medicine they had been taking. This had resulted in a change to the patient's prescribed medicine. An audit of all patients who were prescribed HRT was carried out to ensure that all patients were prescribed appropriately.

We saw that the practice had regularly undertaken internal clinical audits. These audits had included monitoring the medicine of patients with long term conditions. Findings had been shared with staff and actions and recommendations had been recorded. We saw that there was documented evidence of reviews of these audits, so the practice was able to confirm whether the actions identified had been implemented successfully.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to oversee how these were managed and monitored. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, we saw where a nurse who saw a patient regularly had identified a prescription error that had occurred with two medicines with similar names. We saw that practice procedures had been followed, with action taken accordingly.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by email to practice staff. Staff we spoke with confirmed this process. They told us that alerts were discussed at practice and business meetings to ensure everyone was aware of any issues relevant to the practice and what action, if any, needed to be taken. We saw that any action taken had been recorded appropriately.

Reliable safety systems and processes including safeguarding

We saw that Disclosure and Barring Service (DBS) checks had been completed for all staff who worked at the practice. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children.

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had dedicated GPs appointed as leads for safeguarding vulnerable adults and children. The GPs had been trained to the appropriate level. They demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site. Staff explained to us the processes

they would follow in the event they became concerned that a patient may be at risk of harm. For example, a clinician told us about the procedure they had followed recently when they had concerns about children who had attended their clinic.

Patient's individual records were written and managed in a way that helped to ensure their safety. Records were kept on an electronic system (EMIS) which collated all communications about the patient including scanned copies of communications from hospitals. 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.

We saw the system used to highlight vulnerable patients on the practice's electronic records. This included information which ensured staff were alerted to any relevant issues when patients attended appointments.

The electronic system was used for the identification and follow up of children, young people and families who lived in disadvantaged circumstances (including looked after children, and young carers); to highlight vulnerable patients; to review repeat medicines for patients with co-morbidities/multiple medicines, and identify and follow up on children who persistently failed to attend appointments, such as childhood immunisations. We found that GPs used the required codes on their electronic case management system to ensure risks were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consulting rooms. Staff and training records confirmed that chaperone training had been undertaken by all clinical staff, including health care assistants.

Medicines Management

We checked medicines stored in the treatment rooms, medicine refrigerators and other areas at the practice. We found that not all medicines were stored securely and were accessible to unauthorised staff. For example, the key to a stock medicine cupboard was not held securely when not in use. Treatment rooms and other areas where medicines were stored were not secure. Immediate action was taken by the practice to address this. Information that confirmed this action had been completed was sent to us following the inspection. This showed that the storage arrangements for medicines had been reviewed and that all medicines held at the practice were now stored securely. The practice's policies for the handling and storage of medicines had also been updated to reflect these new arrangements.

There was a clear policy and system that ensured refrigerated medicines were kept at temperatures according to manufacturers' guidance. This was being followed by the practice staff, and the action they were to take in the event of a potential failure was described. We found there was no system in place for monitoring temperatures of rooms where non-refrigerated medicines were stored. Immediate action was taken by the practice. A policy and system for ensuring non-refrigerated medicines were stored within the required temperature range was put into place.

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

We saw there were signed Patient Group Directives (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a GP, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Members of the nursing staff were qualified as independent prescribers. We saw that they received regular supervision and support in their role as well as ensuring they kept up to date in the specific clinical areas of expertise for which they prescribed.

There was a protocol for repeat prescribing which was in line with national guidance. We saw this was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank computer generated

prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. However, we found that pads used for handwritten prescriptions were not held securely and were not tracked through the practice. Immediate action was taken by the practice manager to secure these at the time of the inspection. A new Prescription Security policy was produced and a copy sent to us for information following the inspection. This showed that a robust protocol for the management of prescription pads had been put into place.

We saw records of practice meetings that had recorded the actions taken in response to the review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw that an audit of the use of one identified antibiotic had been undertaken by the practice in October 2014. This audit had been carried out because information from the Clinical Commissioning Group (CCG) had identified high use of this medicine by the practice. We saw that this was discussed at a practice meeting and the conclusion and action plan was circulated to all of the GPs at the practice.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Hand hygiene technique signs were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw hand sanitation gel was available for staff and patients throughout the practice including the reception area.

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead had carried out regular audits and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

The practice had policies and systems in place to protect staff and patients from the risks of health care associated infections. For example, we saw the policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella risk assessment had been completed and was kept under regular review. We saw records that confirmed the practice carried out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff what to do in the event of a needle stick injury. We saw evidence that staff had received the relevant immunisations and support to manage the risks of health care associated infections.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule was in place for all portable electrical equipment to be routinely tested, with the next test due in November 2014.

We saw records that confirmed that all measuring equipment used in the practice was checked and calibrated each year. The last calibration was carried out in March 2014. We saw that these were all up-to-date and in good order for the safety of patients and staff

Staffing & Recruitment

Recruitment and selection processes were in place to ensure staff were suitable to work at the practice. We saw a policy which outlined the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. However, the policy did not include information about Disclosure and

Good

Are services safe?

Barring Service (DBS) checks and checks specific to clinical staff. The practice reviewed their policy immediately to include this information and sent a copy to us that confirmed this.

Patients were cared for by suitably qualified and trained staff. There was a system in place that ensured health professionals' registrations were in date. We saw evidence that the GPs and nurses were registered with their appropriate professional body and therefore fit to practice.

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.

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

Monitoring Safety & 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, 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. For example, the practice manager had shared the recent findings from an infection control audit with the team and discussions about action to be taken had been recorded in minutes.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they did not attend.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed 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). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the minutes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning had taken place.

Staff confirmed they knew how to respond to medical emergencies. However, we saw that medicines were not held in a secure area. These included medicines for the treatment of cardiac arrest (heart attack), anaphylaxis (severe allergic reaction) and hypoglycaemia (low blood sugar). The practice policy and procedures for the storage of emergency medicines was reviewed immediately after the inspection. A copy of the revised policy was sent to us. This showed that these medicines were now securely stored but also remained accessible in an emergency.

Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There were systems in place to respond to emergencies and major incidents within the practice. There was a business continuity plan available which identified potential safety risks including changes in service demand, the disruption to staffing levels and loss of domestic services. The practice manager told us about an incident that had happened in the last 12 months where this plan had been used effectively for a gas emergency at their branch surgery.

Risks identified included power failure, loss of main surgery building, loss of medical records, staff shortage and access to the building. The document also contained relevant

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Are services safe?

contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system, and utility services such as electricity, gas and water suppliers. Copies of this plan were held off site with designated management staff. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). GPs demonstrated that they followed local commissioner's protocols regarding clinical decisions such as changes in care pathways.

We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and for patients were discussed and any required actions were agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given the support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

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

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool used to assess performance. We saw there was a robust system in place to frequently review QOF data and recall patients when needed.

The practice had a system in place for completing clinical audit cycles. For example, we saw an audit regarding the prescribing of hormone replacement therapy (HRT), a treatment used to relieve symptoms of the menopause. Following the audit the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records which showed how they had carried out further audits, evaluated the service and documented the success of any changes. Further action plans were put in place where the changes had not been successful.

We saw that clinical staff were appropriately trained and kept up to date with best practice. They carried out regular clinical audits on their records and results of these were used to inform their learning. For example, a practice nurse carried out minor surgical procedures in line with their registration, training and NICE guidance. They showed us examples of audits they had carried out such as audits of incidents of minor surgery post-operative infections. Records we looked at confirmed that no post-operative infection cases had been identified.

The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake regular audits.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computer 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. Where they

Good

Are services effective?

(for example, treatment is effective)

continued to prescribe it they had outlined the reason why they had 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

Staff employed at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with training in areas such as basic life support and safeguarding adults and children. A good skill mix was noted amongst the GPs. Two GPs had additional diplomas in skin conditions, five with diplomas in sexual and reproductive medicine, one with a diploma in child health and two with a diploma in family planning. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a more detailed assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals. We saw that action plans documented all identified learning needs for each appraisal. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example a minor surgery course for one of the practice nurses. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP for support throughout the day. Feedback given to us by a trainee was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, cervical cytology and in minor surgery for one nurse. Those with extended roles such as the nurse practitioner were trained in the diagnosis and management of patients with complex medical conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease. There were also two nurse consultants at the practice who acted independently to the GPs who prescribed, arranged investigations and referred patients to specialist doctors. These nurses were also able to demonstrate they had appropriate training to fulfil these roles. The annual registration fee paid by all of the practice nurses to their professional body to remain registered was funded by the practice.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP who saw the documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings regularly to discuss the needs of complex patients, such as those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service offers patients a choice of appointment at a time and place to suit them. The GPs told us that they completed referrals to another service with the patient as part of the consultation. Referrals were completed either via electronic templates or audio file, and were usually processed on the same day.

We spoke with the deputy manager from a nursing home where patients were registered with the practice. They told us the practice supported patients through regular weekly visits to the home. They also confirmed that the GPs would attend outside these arrangements if necessary and responded promptly to any concerns they had.

Staff told us that the practice provided support for patients through the virtual ward scheme. This scheme had been introduced to help support patients with complex needs.

Good

Are services effective?

(for example, treatment is effective)

The virtual ward was staffed by a team of nurses who worked closely with a patient's own GP and a range of health and social care professionals. The aim of the ward was to improve the quality of life, reduce unplanned hospital admissions, facilitate patients to self-care, to provide end of life care that was appropriate, and provide support and personalised self-management plans.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system (EMIS) was used by all staff to coordinate, document and manage patients' care. All staff were trained on the system. The use of the record system was also discussed at clinical patient care meetings to ensure a consistent approach in the use of these records by clinical staff. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had signed up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out of hours with faster access to key clinical information. Information for patients about this was available on the practice website together with a form to enable patients to opt-out from having a Summary Care Record if they chose.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act (2005), and assessment of Gillick competency of children and young adults. Gillick competency helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

We saw examples of where the guidance had been signed off by the GPs and put into practice. Clinical staff told us that patients had a choice about whether they wished to have a procedure carried out or not. For example, a practice nurse told us how they talked through procedures for minor surgery with the patient, and discussed any concerns or anxieties they had. We were told that if the patient was unsure and needed more time to consider the procedure this was agreed with them. An appointment was made for them to return to the practice to allow them more time to make their decision.

There was a practice policy for documenting consent for specific interventions. For example, the practice nurse showed us the consent forms for all patients where minor surgical procedures had been carried out. The consent form clearly documented the process of referral from the GP to the practice nurse for consideration of the procedure. The documents recorded the assessment and information shared with the patient to enable them to make a decision about the treatment they were to be given. Following assessment an appointment was made for the procedure to be carried out, and the consent process was reiterated and agreed before the surgical procedure was carried out. We were shown an audit that confirmed the consent process for minor surgery had been followed in all of the cases recorded.

Mental Capacity Act training was completed by all practice personnel during a protected time training session at the practice in 2012. Details of the Mental Capacity Act were re-circulated to all partners, salaried GPs, registrars, nurse practitioners and practices nurses on 7 October 2014. A paper copy was made available and an electronic version was available on the Mental Health section of the practice intranet for all staff to access. Staff we spoke with gave examples of how patients' best interests were taken into account where they did not have capacity.

Staff told us the patient always came first and was encouraged to be involved in the decision making process. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. There were 90 patients with a learning disability registered with the practice and annual check-ups had been carried out for 56 of those patients so far this year. We saw examples of records that showed care plans were in place and that reviews had been carried out.

The practice had not had an instance where restraint had been required in the last 3 years. Staff were however, aware of the distinction between lawful and unlawful restraint.

Good

Are services effective?

(for example, treatment is effective)

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews or to review the patient's long term condition.

The practice also offered NHS Health Checks to all its patients aged 40-75 and a call and recall system was in place. A GP showed us how patients who had risk factors for disease identified at the health checks were followed-up and scheduled for further investigations. The practice told us that currently the uptakes of these checks were lower than expected. However, due to new services made available in the county, they expected the uptake to increase as the new service provision meant their capacity to undertake these checks would be increased. A new government initiative had been established in the county of Herefordshire to provide extended hours for patients during evenings and weekends. An agency provided this service and the practice premises were used to facilitate this.

The practice had numerous ways to identify patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. Similar mechanisms were in place to identify at risk groups such as patients who were obese, those patients likely to be admitted to hospital and those patients receiving end of life care. These patient groups were offered further support in line with their needs.

Up to date care plans were in place that were shared with other providers such as the out of hours provider and with multidisciplinary case management teams. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG, and again there was a clear policy and procedure in place for following up non-attenders by either the named practice nurse or the GP.

We saw that a range of health promotion leaflets were available in the reception area, waiting room and treatment rooms. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed smoking, drinking and diet with patients when they carried out routine NHS health checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse.

The practice's performance for foot examinations for patients with diabetes at 93% was better than others in the CCG area. The performance for blood pressure monitoring was similarly better at 94% than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for their clinic appointments and the practice audited patients who do not attend.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice's virtual Patient Participation Group and patient satisfaction questionnaires undertaken by the practice. The evidence from all these sources showed patients were satisfied that they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses. Information showed that 88% of practice respondents said they would recommend the practice and 83% reported an overall good experience of the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 18 completed cards and all but one was 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. The one less positive comment indicated the patient was unhappy because they did not have their own named GP. We also spoke with seven patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff confirmed they ensured patients' dignity was maintained by making sure the door was closed and that screens were used to enable patients to undress in private. Patients were made comfortable and staff told us they offered a chaperone service if patients preferred. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them. We saw leaflets in the reception area and information on the practice website that confirmed this.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff told us 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. We were shown an example of a report on a recent incident that showed that actions taken had been robust. There was also evidence of learning taking place as staff meeting minutes showed incidents had been discussed.

We spoke with the deputy manager of the nursing home where patients were registered with the practice. They described to us the caring, professional, supportive attitude of everyone who worked at the practice from GPs, to nursing and reception staff. They told us nothing was too much trouble and they felt that patients could not receive a better service.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff and were given sufficient time during consultations to discuss any concerns. Patient comments on the comment cards we received were also positive and supported these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from the national patient survey showed 96% of practice respondents said the GP was good at involving them in decisions about their care. This was above the average 87% compared to the Clinical Commissioning Group (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

Are services caring?

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 the population of the patients at the practice were mainly white, British people, with employed and seasonal land workers. There were also a small number of Indian and Chinese patients registered with the practice. Staff told us that support for people whose first language was not English tended to come from their own supporters, although an interpreter service was available. Leaflets in the patient's preferred language were printed from the internet to help them understand their conditions as required. We saw information posters in both Polish and Romanian were displayed in the waiting room.

We saw records that confirmed Mental Capacity Act training had been completed by all practice personnel during a protected time training session in 2012. Details of the Mental Capacity Act were re-circulated to all partners, salaried GPs, registrars, nurse practitioners and practices nurses on 7 October 2014. A paper copy and an electronic version were made available for all staff to access.

Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that the patient always came first and were always encouraged to be involved in the decision making process. They described that they would always speak with the patient and obtain their agreement for any treatment or intervention even if a patient attended with a carer or relative. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose.

Patient/carer support to cope emotionally with care and treatment

Staff told us that families who had suffered bereavement were called and visited by their GP. Staff were aware that families could be sign-posted to other services for support. GPs would assess the support needed and were able to make appropriate arrangements such as a referral to the primary care mental health worker.

Patients we spoke during the inspection and the comment cards we received were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and practice website also signposted people to a number of support groups and organisations. The computer system used by the practice 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.

End of life care and bereavement information was available to patients and their relatives/carers on the practice website and in the waiting rooms. This included information to advise patients what to do if a death occurred at home or in hospital. 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 and or signposting to a support service. The deputy manager of the nursing home told us that GPs always gave support where it was needed, and this often included the family members of patients at the home.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population. For example, the practice had identified patients with mental health illnesses who were supported and treated by the assertive outreach team (who support patients with severe mental health illnesses). The practice arranged to meet with the assertive outreach team on a regular basis. This ensured that information was shared about patients registered with the practice so their mental health, wellbeing and the treatment they received could be monitored.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. GPs told us self-management plan leaflets were available for patients diagnosed with asthma.

The practice had an active virtual patient participation group (PPG) to help it to engage with a cross- section of the practice population and obtain patient views. We spoke with a representative of the PPG who confirmed that patient feedback was sought every three months throughout the year. The representative told us the practice was keen to gather people's views as a way to improve the service provided, although in their view the service provided was already brilliant.

Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

Home visits were made to a local nursing home on a specific day each week. Additional visits were made to those patients who needed a consultation outside of these routine visits.

Tackle inequity and promote equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for an interpreter if required and that information could also be translated via the website.

Female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system available for patients with a hearing impairment and clear signs to indicate where patients were to go for their treatment or consultation.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone

Good

Are services responsive to people's needs?

(for example, to feedback?)

number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients on leaflets, through information displayed in the waiting room and on the practice website.

The practice opened from Monday to Friday from 8am to 6pm each week. Hampton Dene Surgery opened from Monday to Thursday from 8.30am to 5 pm (closed 12.45pm to 1.45pm) and on Fridays from 8.30am to 12.45pm.

All clinics were available by appointment and patients could book these by telephone, online or at the reception desk at the practice. The practice offered additional appointments on Monday evenings from 6.30pm to 8pm with a GP, nurse practitioner and a practice nurse. These appointments were particularly useful to patients with work commitments. Working age patients were able to access appointments through the online booking system. We spoke with two patients from this population group during the inspection who told us this system was easy to use. Text message reminders for appointments and test results, online or telephone consultations where appropriate, and support was provided to enable people to return to work promptly.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

We saw that procedures were in place and followed to respond to patients who arrived late for, and/or failed to attend appointments. These procedures made sure patients were clear about their responsibilities to keep to their appointments and the possible implications for their non-attendance. The practice took steps to check with patients when they had failed to attend their appointment and offered reminders for future appointments and further support if this was needed. This worked to make sure that all patients had access to appointments as they were required and not blocked by patients who failed to keep their appointments. Information about these procedures was clearly displayed in the waiting room.

The practice was accessible to patients. 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. Information leaflets for health promotion were available for patients to take away with them should they wish to do so.

The practice had a population of mostly English speaking patients though it could cater for other languages through translation services.

Listening and learning from concerns and complaints

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

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions had been taken to resolve each complaint as far as possible. Records showed that 17 complaints had been received during 2014. We saw that these complaints had been handled satisfactorily.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Accessible information was provided to help patients understand the complaints system on the practice's website, posters displayed in the waiting room and in the reception area. The practice provided patients with a yellow box which was available in the waiting room where comments, complaints and suggestions could be made. Patients were advised these could be made either anonymously or with contact details so that a response could be made by the practice.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The GPs and the practice manager told us that complaints were discussed at the weekly management meetings. We saw that the outcome and learning from complaints was then shared with the staff team at team meetings.

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

There was a clear and visible leadership and management structure in place. Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with one GP who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs, practice manager and team leaders were very supportive.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at eight of these policies and procedures. All eight policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice had completed a number of clinical audits. For example, we saw completed audits for the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as spillages. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for the practice for risks identified such as needle stick injuries.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the partners was the lead for safeguarding and the Caldicott Guardian. Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Staff felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least bi-monthly or sooner if needed. Staff told us that there was an open culture within the practice and they had the opportunity and felt comfortable to raise any issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction policy, recruitment and equal opportunities policy which were in place to support staff. Staff told us there was a staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patients' surveys and complaints received. The practice had an active virtual patient participation group (PPG). The

Are services well-led?

Good

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

group has been in place for two years and new membership was being sought via notices in the waiting rooms in both Cantilupe and Hampton Dene Surgeries. The PPG contained representatives from various population groups; including mothers, working age and older people.

The PPG had carried out an online survey in conjunction with a patient survey completed by the practice. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results were very positive for the practice and showed that patients were happy with the service they received. A copy of the report and the actions agreed from these surveys were available on the practice website.

The practice shared the results with the whole team for discussion at a surgery education session in January 2014. This gave staff the opportunity to give feedback on any of the findings from the survey report. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

We saw from minutes that staff meetings took place every two months. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon. One member of staff told us that they had asked for specific administration time and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff confirmed they knew who to talk with in the event they had any concerns.

Management lead through learning & improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings, clinical staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

We saw how the practice responded to areas that needed to be improved. For example, the practice had identified the need for clinical staff training to improve the service provided for people with learning disabilities (a vulnerable group of people considered to be at risk). Training was scheduled to take place in October 2014 for all clinical staff.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated and actioned. For example, we saw that the outcome of complaints received and resolved had been discussed at the management meeting held on 26 August 2014. We saw the practice significant events log for 2014 which gave details of the incident, who was involved, action taken and lessons learned.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. We looked at three staff files and saw that regular appraisals had taken place and personal development plans had been completed. Staff told us that the practice was very supportive with training and that they had regular protected time provided for learning.

Cantilupe Surgery was an approved GP teaching practice. Three of the partners were trainers and they told us they supervised and supported the work of the trainee GPs when working in the practice. They told us they were always available for advice if required and held regular supervision meetings to clarify any learning points as needed.