Howell 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.

Summary of findings

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Summary of findings

Overall summary

Howell surgery is a GP practice providing primary care services for around 4900 patients. There are three GPs who are in partnership. The main surgery is in the village of Brenchley, there is a branch surgery in the neighbouring village of Horsmonden. Howell surgery has its own medicine dispensary. Patients seen at the branch surgery may collect their medicines from Howell surgery following their consultation. During our inspection we visited Howell surgery only.

We only visited Howell Surgery in Brenchley for this inspection.

As part of the inspection we talked with the local Clinical Commissioning Group, the local Healthwatch, a member of the Patient Participation Group, patients who were at the Howell surgery on the day of the inspection, doctors and other clinical and non- clinical staff at the practice.

The patients we spoke with and those that left comment cards were very satisfied about the care and treatment they received. We did not receive any negative feedback with all patients saying they received very good or excellent care. Patients said that the appointment system worked very well and no one had any cause for complaint.

The practice provided caring, responsive, effective and well led services. Although the services provided by the practice were safe, we identified some concerns in relation to the storage of medicines.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the services provided by the practice were safe. However, we had concerns about the management of medicines and have asked the practice to make changes to address these concerns.

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment. Many commented that the practice was excellent, others said that it was very good.

We found systems were in place to ensure staff learned from significant events. There was an open and inclusive style of management where staff felt confident to report incidents, significant events and errors.

Staff understood their roles and responsibilities in relation to safeguarding both vulnerable adults and children.

No risk assessments had been completed regarding the safe storage of medicines and the dispensary was not secure.

The practice was clean and there were systems in place to minimise the risk of infection to patients, staff and other visitors to the practice.

Are services effective?

We found that services provided by the practice were effective. Professionally recognised best practice and national guidelines were followed by the practice. The practice had set up an effective multidisciplinary team meeting which took place every month. A range of professionals attended so that the effectiveness of individual patients' care could be assessed and monitored. Audits were in place, some of which were shared externally so that the practice could compare itself to other local practices.

Are services caring?

We found the practice was caring. All of the feedback we received from patients was very complimentary about the practice and about individual staff members. Interactions we observed and heard between staff and patients were compassionate, polite and friendly. Patients said that staff took time to ensure their privacy and dignity was respected especially when intimate examinations took place. Patients told us the practice was welcoming, family friendly and met their needs.

Summary of findings

Are services responsive to people's needs?

We found that the practice was responsive to patients' needs. We found patients were asked for their views about the practice and action was taken as a direct result of their feedback. The practice had set up an active and involved Patient Participation Group (PPG) which was independent of the staff from the surgery. We found the appointments system met patients' needs and they commented very positively about how flexible it was. We looked at the complaint information and log of complaints. Information about how to complain was available and the practice had not received any complaints for five years.

Are services well-led?

The practice was well-led. The culture at the practice was open and inclusive. Staff had clearly delegated roles and the management structure was well established. Governance arrangements were in place, to continuously improve the service.

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
We found that the practice was responsive to the needs of older patients. Plans were underway for every patient who was over 75 to have an allocated GP. This group of patients were being contacted to inform them which GP they were to be allocated. They were also being informed that they may see any GP they chose, not just the one allocated to them. A service was also being set up for patients with memory problems

People with long-term conditions
The practice was responsive to the needs of patients with long term conditions. Arrangements for regularly reviewing patients with long term conditions were in place. Staff contacted patients asking them to arrange a convenient time for a review at intervals specific to their needs. For example, patients with hypertension (high blood pressure) were asked to attend the practice every six months. This meant that patients had their symptoms and needs reviewed regularly and care and treatment could be adjusted to keep them in good health

Mothers, babies, children and young people
The practice worked flexibly around the needs of this population group. A midwife saw patients at the surgery on a set day on a weekly basis. No other specific clinics had been set up, so patients could be seen on any day by either practice nurses or one of the GP

The working-age population and those recently retired
No separate information was available beyond the fact that the surgery had flexible appointments to meet the needs of this group

People in vulnerable circumstances who may have poor access to primary care
No separate information was available beyond the fact that the surgery had flexible appointments to meet the needs of this group

People experiencing poor mental health
No separate information was available beyond the fact that the surgery had flexible appointments to meet the needs of this group.

Summary of findings

What people who use the service say

We spoke with four patients at the practice, received comment cards from 14 patients and we looked at feedback the practice had received. Patients were very satisfied with the care and treatment they received from all members of staff. Patients commented that the systems in place for seeing the doctor were good and meant that they could see a doctor when they needed to. Patients felt listened to and were confident that if they had any concerns about the practice or its meeting their own needs, they would be acted upon.

We received comments about how friendly the staff were and patients commented that the practice was very good or excellent. We did not receive any negative comments or suggestions about how the practice could be improved.

Areas for improvement

Action the service MUST take to improve

The practice must carry out a risk assessment regarding the safe storage of medicines in the practice.

A system must be put into place to ensure that expired medicines are removed from use.

Action the service COULD take to improve

The practice could formalise their appraisal process by ensuring that there was documentary evidence of the discussions.

The practice could consider that all dispensary staff undertaking the final dispensary accuracy check complete a recognised training course

Howell Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our Inspection team was led by a Care Quality Commission (CQC) lead inspector and a GP. The team included a CQC pharmacist inspector and a practice manager.

Background to Howell Surgery

Howell Surgery is a GP practice based in the village of Brenchley. The surgery offers primary medical services including practice nurse services. A midwife also works from the surgery on a weekly basis.

Howell surgery is the main practice and there is a branch practice at Horsmonden called The Surgery. Both the surgeries serve patients living in the Brenchley and Horsmonden area. There were approximately 4900 patients on the list at the time of our inspection.

Howell surgery is a dispensing practice, so patients living beyond 1.6 kilometres of a registered pharmacy could have their prescriptions filled at the practice, as set out by NHS guidelines. Howell surgery has a higher number of over 65 year olds and 18yrs and under age groups. The practice is provided to a population with low levels of deprivation and a small number of patients whose first language was not English. This was in comparison to the national average. Howell surgery and The Surgery at Horsmonden are wheelchair accessible. Extended hours are provided at both surgeries on Monday evening until 7.15pm and at Howell surgery on Wednesday evenings until 7pm.

This was the first inspection of Howell surgery and services were also provided from the branch surgery – The Surgery in Horsmonden.

Staff told us that patients could choose which surgery to visit for their consultation.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Detailed findings

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 16 May 2014 between 09.30 - 15.30.

During our visit we spoke with a range of staff, including GPs, a practice nurse dispensary and reception staff, administrative staff and the practice manager.

We observed how patients were being cared for and talked with carers and/or family members. We saw how telephone calls from patients were dealt with. We toured the premises and looked at records of audits and policies. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice.

Are services safe?

Summary of findings

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment. Many commented that the practice was excellent, others said that is was very good.

We found that systems were in place to ensure staff learned from significant events. There was an open and inclusive style of management where staff felt confident to report incidents, significant events and errors.

Staff understood their roles and responsibilities in relation to safeguarding both vulnerable adults and children.

We found that no risk assessments had been completed regarding the safe storage of medicines and the dispensary was not secure.

The practice was clean and there were systems in place to minimise the risk of infection to patients, staff and other visitors to the practice.

Our findings

Safe patient care

Staff described how significant events were analysed. A standard form was used to record events and all staff had access to the forms on the computer system. The forms included details, times and the identifying member of staff. The completed forms were then given to the practice manager who shared this with one of the GPs. Urgent problems were discussed between the doctors who met regularly, on an informal basis. In addition, problems and events were discussed at the regular bi-monthly staff meetings. Staff told us, and minutes of meetings showed us, that several sources of information were reviewed to assess how safe patient care was. This included the review of results of audits, feedback from patients, carers and other professionals and clinical audits.

Patients we spoke with and information we had from the comment cards showed that patients felt that they were safely cared for. Comments made included the fact that the surgery was always clean and that all staff from the receptionists to the doctors were very helpful and supportive.

Staff working on reception told us about how they responded if a patient became particularly unwell, whilst waiting to see the doctor. One staff member told us that when this happened they sent a message via the computer to the doctor which informed them that the patient needed to be seen as a priority. The reception staff then changed the order of the list, so that the unwell patient could be seen next.

Learning from incidents

We saw that the practice had a robust incident reporting system and that they learned from incidents. We looked at two significant events that had occurred at the practice. One example related to a letter received from a hospital requesting referral of a patient to the community team for specific care. The patient had then developed a medical condition but the referral had been missed as the letter was filed before it was read by a GP. As a result of the incident the process for filing and reviewing referrals was reviewed and reinforced with staff. Following this incident all letters had to be stamped on receipt to identify the action to be taken. If this was not completed the member of staff tasked with scanning and filing the record was to bring it to the attention of one of the doctors.

Are services safe?

There were also a number of other significant events relating to clinical care that we discussed with doctors. A total of 12 were completed the previous year and these had been reported to the Clinical Commissioning Group (CCG) in accordance with procedures. The staff discussed learning points at staff meetings and learnt from incidents that took place. Staff told us that they felt valued and that they were encouraged to participate fully in meetings. We saw that the practice acted on incidents and put measures in place to prevent them happening again and to improve processes to protect patients.

Safeguarding

One of the three GPs was the nominated lead for safeguarding. This meant that this GP had received training in safeguarding for children and vulnerable adults to a more advanced level than the other staff. All of the clinical staff had received safeguarding training to the appropriate level. This was confirmed by looking at training records for staff. Staff we spoke with were confident about their responsibilities and knew where to locate guidance and contact details of other organisations, should they need to refer a patient.

Systems, training and information was in place to keep patients safeguarded from abuse as far as possible. In addition to training of staff we saw that regular multidisciplinary meetings to discuss the management and care of potentially vulnerable patients had been set up and these took place on a monthly basis. We saw that a policy for chaperoning was in place. We found that occasionally one of the non-clinical members of staff chaperoned patients, a risk assessment was put in place as this person had not been subject to a Disclosure and Barring Service (DBS) check.

Monitoring safety and responding to risk

Staffing levels at the main surgery were adjusted according to demand. The doctors' consulting times changed in accordance with need. Patients we spoke with told us that they had never experienced any problems in getting an appointment with either the GPs or nurses.

Staff working on the reception told us about how they responded if a patient became particularly unwell, whilst waiting to see the doctor. One staff member told us that when this happened they sent a message via the computer to the doctor which informed him that the patient needed to be seen as a priority. The reception staff then changed the order of the list, so that the unwell patient could be seen next.

GPs at the practice told us how they conducted their consultations with patients. They used their knowledge of the patient, listened to patients describe their symptoms and drew on their expertise to judge the level of risk to patients. Decisions about when to refer patients were made by suitably skilled staff.

We saw that all staff received training in basic life support. This helped ensure that they could respond appropriately in the event of a medical emergency.

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We found that there was an effective and safe process for monitoring the health of patients taking certain medicines.

We saw that the surgery had a small supply of medicines for use in emergency. One of the doors leading to the dispensary where medicines were stored was not secure. However, the dispensary always had staff in attendance when the surgery was open. A risk assessment in respect of the security of the dispensary had not been undertaken.

The practice stored vaccines and medicines that required refrigeration in dedicated refrigerators which records demonstrated had been kept within the correct temperature range. The key for the refrigerator in the treatment room was not kept secure. Vaccines were transferred between the two surgeries in validated cool boxes which maintained the cold chain. The temperature of the treatment room where some medicines were stored was not recorded which posed a risk that medicines could have been stored at higher temperatures than recommended by the manufacturer. We found medicines that had passed their expiry date in one consulting room and in the treatment room. These were removed when we brought this to the attention of staff. The storage of medicines had not been risk assessed, so systems had not been put in place to minimise the risks.

Most of the staff that dispensed medicines had undertaken an approved training scheme. One member of staff who did not have the training had many years of experience and was assessed as competent in dispensing medicines.

Are services safe?

Although experienced, none of the staff undertaking dispensing final accuracy checks had undertaken approved training. This training is recommended for good practice. This meant that there was a risk that final checks were not made safely.

There was a record book kept by the dispensers. Here they recorded any prescribing or dispensing errors. These were then discussed by the doctors both informally and at the staff meetings, where lessons were learnt and actions were taken to try to prevent these happening again. We saw that dispensing issues and errors were regular items on the agenda at staff meetings. One meeting recorded that a dispensing error had been escalated to a significant event. We saw that as a result of this incident staff had been reminded about the importance of keeping the surgery open in accordance with their agreed opening times and a letter of apology had been sent to the patient.

Processes were in place for stock taking and reordering as well as safe disposal of medicines.

We found that there were safe and reliable systems for prescriptions and repeat prescriptions. Patients living within 1.6 kilometres of the practice could have their prescriptions filled at the dispensing service at Howell Surgery in line with NHS and government guidelines. Patients could order repeat prescriptions at the surgery, by post or online. The practice indicated the process for reordering and period of time to fill the prescription clearly in their patient information leaflet. This meant that clear information was available for patients who needed medicines.

Cleanliness and infection control

We found systems were in place to promote safety in relation to infection control. One of the practice nurses was the nominated lead person. This meant that they were responsible for checking and ensuring that the practice reduced the risk of infection to patients and staff. This nurse conducted informal checks of cleanliness, ensured that personal protective equipment (PPE) was available, and checked that cleaning schedules were adhered to. The checks were not documented, but during our inspection of the premises we found all areas appeared clean and were stocked with PPE. We saw that couch roll was available in all the rooms with examination couches. Checklists to show cleaning of areas and equipment had been completed were not always signed, but we noticed there had been an improvement in the completing of this information in the last month. The practice manager told us this was because she had asked staff to be more vigilant as this provided evidence that cleaning had taken place. Patients we spoke with stated the environment was always clean.

We saw that the treatment room where minor operations and procedures were carried out had special flooring that could be easily cleaned. This room also contained a washable privacy screen which could be easily cleaned. The consulting rooms were carpeted, but staff told us that only non-invasive examinations were carried out in these areas. One of the practice nurses described the procedures to clean or dispose of equipment after use. This meant that the risk of cross infection was reduced.

Staffing and recruitment

The majority of staff had worked at the practice for many years, with only two staff joining since the practice registered with the Care Quality Commission. The practice manager showed us the recruitment records of the two newest staff. We saw that not all of the recruitment checks were present in the files. Neither contained a photograph or written references. The practice manager told us that verbal references had been sought. The practice manager sent us information following our inspection to provide evidence that written references had been requested and would be placed in the files and that both staff members had photographs copied and these were now on their files. Action had been taken to ensure the recruitment of staff was as safe as possible and the documentary evidence was now in place.

Dealing with Emergencies

There were procedures and equipment in place in the event of emergency to maintain patients' safety. This included stocks of medicines for use in emergency. There was also an automated external defibrillator (AED) and oxygen. This equipment was checked daily or after use to ensure it was safe. Appropriate staff received training at regular intervals in basic life support and in using the AED to ensure that they were able to respond appropriately to any cardiac events. We found that contingency plans for other emergencies such as pandemics and fire were also in place.

Equipment

We found that there were processes in place for the maintenance and servicing of equipment. Portable appliances were tested on a regular basis and we found fire

equipment was regularly checked. The automated external defibrillator had a self-check mechanism which was checked by the practice nurses. Clinical equipment was checked by the practice nurses and the practice manager checked non-clinical equipment such as office furniture. This meant that designated staff took responsibility for minimising risk in relation to equipment.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found that the services provided by the practice were effective. Professionally recognised best practice and national guidelines were followed by the practice. The practice had set up an effective multidisciplinary team meeting which took place every month. A range of professionals attended so that the effectiveness of individual patients' care could be assessed and monitored. Audits were in place, some of which were shared externally so that the practice could compare itself to other local practices.

Our findings

Promoting best practice

We saw that relevant guidelines and national strategies were available for staff to refer to on the computer. We found that the practice was proactive in working to best practice. Auditing processes were in place to ensure that the practice worked within nationally recognised good practice guidelines. We found that the practice had high scores with Quality and Outcomes Framework (QOF) audits.. We found that one of the GPs who performed minor operations audited their own work and shared their findings with the Clinical Commissioning Group (CCG). The GPs at the practice had recently introduced the local prescribing formulary. They were also involved in drawing up the local falls protocol and deep vein thrombosis (DVT) care pathway. This meant that the practice was involved in implementing national and professionally recognised good practice.

Management, monitoring and improving outcomes for people

The practice manager was new in post and was in the process of creating an audit plan. The practice manager told us that, as part of the plan, audits of health and safety, and infection control would be carried out. The practice already audited medicines and had begun to audit patients' notes whilst the practice changed from a paper system to a fully computerised system. The practice manager was also in the process of auditing staffing hours. This was to establish if protected time was needed for staff to complete administrative tasks.

We found that the practice had achieved high score in the Quality and Outcomes Framework (QOF) audits. We found that the surgery had already investigated and satisfied themselves that they had taken action where they had achieved worse than expected scores. One of these areas for example was that they had prescribed more than the expected rate of broad spectrum antibiotics. The practice had already looked into this and found that a small number of patients with complex needs had needed additional courses of antibiotics. This had affected the practice's score.

Staffing

We received very positive feedback about the ease of being seen by the GPs. Patients said that they had not experienced any difficulty and had never had to wait an

Are services effective?

(for example, treatment is effective)

excessive amount of time to get an appointment. This indicated that staff were employed in appropriate numbers to meet the needs of the patients. Patients we spoke with and those we obtained comments from were all very happy and satisfied with the treatment, help and advice that they received from everyone, both in the Brenchley and Horsmonden surgeries. They were happy with the advice and care from the doctors and felt that the doctors listened to them. They told us that they were always seen by the appropriate member of staff in a timely way. Patients said that they felt their individual needs were understood by the clinical staff.

The practice manager was in the process of creating a system of tracking staff training. This was so that she could see what training staff had undertaken and when updates were due quickly and efficiently. We found that staff received regular training on designated days throughout the year when the surgery was shut to ensure their knowledge was kept up to date. Both the GPs and nursing staff met the requirements of their regulating bodies for ongoing professional development and this was monitored through supervision and appraisal. This meant that staff received training to update their skills and were subject to supervision and appraisal on a regular basis. However, we noted that supervision tended to be informal and was not unrecorded.

Working with other services

We found that the practice had a formal arrangement with another surgery to provide cover for patients one day per week when the surgery was closed for training. This was a reciprocal arrangement. Patients we spoke with had not experienced any difficulty getting appointments on these days. We found that the practice held a monthly multidisciplinary meeting (MDT). This was attended by at least one of the GPs and a range of other health and social care professionals attended according to the changing needs of the patients discussed at the MDT. We looked at the minutes of two MDT meetings and found that they were attended by district nurses, hospice nurse specialists, and care managers from Social Services, as well as staff from long term dependency services. Clinical staff told us that these provided an opportunity to review patients' care and to ensure relevant skilled professionals could discuss the management of and participate in decision making, for patients with complex needs.

Health, promotion and prevention

We saw among the leaflets and posters displayed in the waiting room, there were some with information about health promotion. Staff we spoke with told us that health promotion advice was given routinely when patients were seen. Staff told us that when patients registered with the practice a full new patient assessment was undertaken. One of the patients we spoke with told us that healthy eating and exercise was discussed with them when they had their new patient assessment. Staff told us about the systems in place for recalling patients to complete courses of vaccinations. This helped ensure that patients received advice and treatment to promote good health.

Are services caring?

Summary of findings

We found that the practice was caring. All of the feedback we received from patients was very complimentary about the practice and about the individual staff. Interactions we observed and heard between staff and patients were compassionate, polite and friendly. Patients told us that the practice was welcoming, family-friendly and extremely good.

Our findings

Respect, dignity, compassion and empathy

The position and layout of the reception desk made having confidential discussions difficult, as it was within the waiting room. We asked staff how this was managed. They said that if patients needed a confidential conversation they were invited into an unused room. Patients told us they really liked the surgery as it was family friendly and they were known by name.

Patients said that the staff were kind and efficient and that they were very happy with the care provided. They told us, and we saw that, the reception staff were polite and helpful.

Patients also told us that they were always treated with respect and compassion, with staff being pleasant, approachable and considerate.

During our inspection we saw that when a patient required an intimate examination, the GP swapped rooms so that screens could be used to protect the patients' privacy and dignity. We heard how telephone calls to the practice were dealt with and how patients were spoken to. We found that staff were polite and helpful. Staff told us that their aim was to treat patients how they would want to be treated. One staff member reiterated that sometimes people can be worried when they are feeling unwell, and staff have to try to reassure them.

Involvement in decisions and consent

Patients we spoke with told us that they felt involved in their care and were given the information they needed to make decisions. Patients felt that the practice was very receptive to feedback and suggestions. Patients we spoke with told us they found information given to them during consultations was clear and they felt free to ask questions if necessary. Patients said they had enough time during their appointment to discuss treatments or medicines that could be used to help them. They felt that staff took the time to explain their health conditions. This meant that patients were involved in decision making and had the time and information to make informed decisions.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found that the practice was responsive to patients' needs. We found that patients were asked for their views about the practice and action was taken as a direct result of their feedback. The practice had set up an active and involved Patient Participation Group (PPG) which was independent of the staff from the practice. We found that the appointments system met patients' needs and they commented very positively about how flexible it was. Information about how to complain was available, and the practice had not received any complaints for five years.

Our findings

Responding to and meeting people's needs

We found that the practice had an active Patient Participation Group (PPG), the group met regularly, and published minutes of their meetings on the practice's website. The minutes were also displayed to patients in the waiting rooms in both practices. The PPG was responsible for gathering the views of patients, by surveying patients that used the practices. This was then fed back to the practice for them to implement changes and improvements. The practice also gathered comments and we saw how patients' comments affected change. For example, some patients had commented that they would like staff to wear name badges. On the day of our inspection we saw that all staff wore name badges.

Access to the service

We received very positive feedback through the comment cards about the appointment system and access to the practice. Patients felt that the opening times were appropriate and suitable and were very supportive of the walk-in surgery in the mornings, giving access to a doctor when there might not have been an appointment slot for several days. We were told patients were happy with the availability of appointments and one patient said they often used the booking system but were happy with being able to use the drop in system. They told us they thought it was a good combination. Patients also told us that the option of talking to the GP by telephone was also very useful. This meant that patient found access to the practice met their needs and expectations.

Concerns and complaints

The four patients we spoke with told us that they had never had cause to complain but knew that there was information in the waiting room about how to make a complaint should they need to.

We found that the practice used the Kent Local Medical Committee (LMC) format for complaints. Leaflets about how to make a complaint were in the waiting room. We looked at the complaints reporting documents and log. We found that the practice had not received any formal complaints in five years.

Are services well-led?

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

Summary of findings

The practice was well-led. The culture at the practice was open and inclusive. Staff had clearly delegated roles and the management structure was well established. Arrangements and systems were in place, to continuously improve the practice.

Our findings

Leadership and culture

All of the staff we spoke with described an open and inclusive culture at the practice. Staff said that their views and ideas were valued and meeting minutes we saw showed that all staff were encouraged to participate fully. Staff members said that if they had any problems or ideas they could just talk about them. Staff said that there was a clear management structure with clear allocations of responsibilities which included named staff for safeguarding and infection control. There was a stable staff team, with only two staff having joined more recently. The practice manager was new in post and was in the process of finding out what systems worked well, and what work was needed to improve others. The practice benefitted from strong and inclusive leadership from the senior partner GP. Staff said that the practice manager had settled in well and was a welcome addition to the team. We spoke with a person from the Patient Participation Group (PPG). They confirmed that staff at the practice were open to criticism and suggestions and valued feedback from patients and the PPG.

Governance arrangements

We found that robust governance arrangements were in place. These set out staff roles and responsibilities and ensured quality and risks were continuously monitored. Many of the staff had lead roles which meant that they took responsibility for different areas of the general running of the practice. For example: a member of the reception staff was the designated lead for fire safety; one of the practice nurses lead for infection control and one of the GPs took responsibility for the management of medicines and the dispensary.

Significant events were discussed openly at team meetings and we found that team meetings were used to learn from incidents and errors. The senior partner told us that he found his role on the board of the Clinical Commissioning Group (CCG) useful in that it informed him of good practice at other surgeries which he could bring back to Howell Surgery. We found that the practice openly shared relevant information with the CCG, for example, the audits into the effectiveness and safety of the minor operations

Are services well-led?

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

undertaken. We found that the practice had a reciprocal arrangement for cover with another local practice for one afternoon per week. This allowed staff from each practice to ensure vital administrative work was carried out.

Systems to monitor and improve quality and improvement

We found that the practice achieved high scores in the Quality and Outcomes Framework audits (QOF). The practice performed well in comparison with other GP practices when their results were compared with other practices in the area. We found that audits were carried out to monitor the quality of the practice, which included auditing some aspects of medicines management, infection control and records management. The practice manager was in the process of reviewing what other audits might be needed such as health and safety.

Within the locality there were six practices that worked together to peer review and audit some parts of each practices' work. These included a review of hospital referrals. The quality of the referral and the outcomes were looked at. The attendance and reason for patients attending A&E was also peer reviewed at these regular meetings. This meant that some aspects of patient care were checked by other professionals to assure the quality of care patients received.

Patient experience and involvement

The practice had an active Patient Participation Group (PPG) which met formally every four months. We spoke with a person from the PPG who confirmed that the practice was very open to criticism and ideas. The PPG was planning to have a stall at the local village fete to promote the work of the PPG, gain more feedback from patients and to try to recruit more members. The PPG meetings had been chaired by staff from the surgery when the PPG was first set up. These were now chaired and attended by members of the PPG unless they specifically invited staff from the surgery to attend. The PPG had conducted a survey of patients' views and a full analysis had been carried out. We saw that the practice had responded to all suggestions and ideas. For example, patients asked that seasonal health tips be available. So the staff had made leaflets available in the waiting rooms. Comment cards stated that this was a well-run practice.

Staff engagement and involvement

Both clinical and administrative staff told us that they felt part of the team. They told us that they were encouraged to share ideas and to comment on the running of the practice. Staff told us that whilst there was strong leadership there was an open and inclusive atmosphere. Staff told us that they were very happy working at the practice and felt listened to and valued. We saw minutes of staff meetings which showed the contributions staff made. This meant that staff were encouraged to feedback ideas about how the practice was run and put forward suggestions for improvements.

Learning and improvement

Staff received regular training updates and protected time for training days was given throughout the year.

We saw that staff received an annual documented appraisal and ongoing informal supervision, which was not recorded. Staff we spoke with felt they received the support they needed. This meant that staff were given the training and support to enable them to perform their roles confidently.

Identification and management of risk

We found that some risk assessments were in place and some areas of risk such as significant or adverse events were discussed at team meetings. We saw that contingency plans for dealing with emergencies were in place and we saw that the plans had been reviewed recently. This plan covered emergencies such as major incidents and pandemics. The practice manager was not able to confirm if health and safety audits had been carried out. This meant that many areas of risk had been identified and plans had been put in place, with the exception of some aspects of medicines management and general health and safety. However, this was in the process of being addressed at the time of our inspection.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

We found that the practice was responsive to the needs of older patient. Plans were underway for every patient who was over 75 to have an allocated GP. This population group were being contacted to inform them which GP they were to be allocated and to inform them that they may see any GP, not just the one allocated to them. A service was also being set up for patients with memory problems.

Our findings

We found that the practice had a plan in place to allocate every patient over 75 years a named doctor. Those patients who requested to see a specific doctor for their appointments were to be allocated to that doctor. The GPs had expressed concerns that this could make patients feel that they could only be seen by the allocated doctor. Therefore the practice was in the process of contacting these patients to explain the reasons for the allocation but to confirm that patients could see any of the GPs as usual. The practice was giving patients information about the Governments' drive for over 75 year olds to have an allocated GP and were trying to continue to offer patients choice and flexibility.

We found that the practice held a monthly multidisciplinary meeting (MDT). This was attended by at least one of the GPs and a range of other professionals attended according to the changing needs of the patients discussed at the MDT. We looked at the minutes of two MDT meetings and found that they were attended by district nurses, hospice nurse specialists, and care managers from Social Services, as well as staff from long term dependency services. Clinical staff told us that these provided an opportunity to review patients care and to ensure relevant skilled professionals could discuss the management of and participate in decision making, for patients with complex needs. This meant that individualised care was monitored to ensure it was effective.

One of the patients we spoke with told us that healthy eating and exercise was discussed with them when they had their new patient assessment. Staff told us about the systems in place for recalling patients to complete courses of vaccinations. This helped ensure that patients received advice and treatment to promote good health.

Howell Surgery was in the process of setting up a service run by a community psychiatric nurse (CPN) with a special interest in memory problems.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice was responsive to the needs of patients with long term conditions. Arrangements for regularly reviewing patients with long term conditions were in place. Staff contacted patients asking them to arrange a convenient time for a review at intervals specific to their needs. For example, patients with hypertension or high blood pressure were asked to attend the surgery every six months. This meant that patients had their symptoms and needs reviewed regularly and care and treatment could be adjusted to keep them comfortable.

Our findings

We found that regular appointments to review their health needs were scheduled for patients with long term conditions. We found that patients with conditions such as hypertension were seen every six months, others with conditions such as ischaemic heart disease (IHD) were seen annually. The frequency of reviews was dependent on the severity of the condition. At these appointments patients had their general health assessed as well as any symptoms specific to their long term condition. They also had their medication reviewed.

We found that the practice held a monthly multidisciplinary meeting (MDT). This was attended by at least one of the GPs and a range of other professionals attended according to the changing needs of the patients discussed at the MDT. We looked at the minutes of two MDT meetings and found that they were attended by district nurses, hospice nurse specialists, and care managers from Social Services, as well as staff from long term dependency services. Clinical staff told us that these provided an opportunity to review patients care and to ensure relevant skilled professionals could discuss the management of and participate in decision making, for patients with complex needs.

One of the patients we spoke with told us that healthy eating and exercise was discussed with them when they had their new patient assessment. Staff told us about the systems in place for recalling patients to complete courses of vaccinations. This helped ensure that patients received advice and treatment to promote good health.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice worked flexibly around the needs of this population group. A midwife saw patients at the surgery on a set day on a weekly basis. No other specific clinics had been set up, so patients could be seen on any day by either practice nurses or one of the GPs.

Our findings

Other than the weekly midwifery clinic, the practice did not have any specific clinics for this population group. If a child needed an appointment to receive an immunisation they could be booked at any time convenient to mother and child. Postnatal women were seen at a time to suit them. There were range of patient information leaflets and posters including information about local breastfeeding support groups and play groups for mothers with babies or young children.

One of the patients we spoke with told us that healthy eating and exercise was discussed with them when they had their new patient assessment. Staff told us about the systems in place for recalling patients to complete courses of vaccinations. This helped ensure that patients received advice and treatment to promote good health.

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Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Early pilot, not formally assessed.

Our findings

Early pilot, not formally assessed.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Early pilot, not formally assessed.

Our findings

Early pilot, not formally assessed.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Early pilot, not formally assessed.

Our findings

Early pilot, not formally assessed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13. HSCA 2008 (Regulated Activities) Management of Medicines. People who use services were not protected against the risk associated with unsafe management of medicines. Because medicines were not stored securely, a risk assessment had not been completed in respect of how medicines were stored and some medicines had passed their expiry date and had not been disposed of. Regulation 13.