Townsend House Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Townsend House practice was inspected on Tuesday 14 October 2014. This was a comprehensive inspection.

Townsend House provides primary medical services to people living in the town of Seaton and the surrounding areas. The practice provides services to a diverse population age group and is situated in a town centre location.

At the time of our inspection there were approximately 6200 patients registered at the service with a team of three GP partners. GP partners held managerial and financial responsibility for running the business. In addition there were three part time salaried GPs, three registered nurses, two healthcare assistants the practice manager, and additional administrative and reception staff.

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

Our key findings were as follows:

Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice was clean, well organised, had good facilities and was well equipped to treat patients.

The practice valued feedback from patients and act upon this. Feedback from patients about their care and treatment was consistently positive. We observed a non discriminatory, person centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

Summary of findings

The practice was well-led and had a clear leadership structure in place whilst retaining a sense mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

People's needs were assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health.

Documentation about the practice demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area. Patients told us they felt safe in the hands of the staff and felt confident in clinical decisions made.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was performed and communicated, although the written evidence for this process did not always consistently show what learning and actions had been taken following such investigations.

We saw one area of outstanding practice:

Specific appointments were made which supported and treated patients with diabetes; they included education for patients to learn how to manage their diabetes through the use of insulin. Health education about healthy diet and life style for patients with diabetes was provided. The practice also held a virtual diabetic clinic with two other GP practices and a hospital diabetic consultant. This is a time where patients with complex needs could be discussed confidentially with the specialist, and GPs received education on the management of patients with complex cases. There were also areas of practice where the provider needs to make improvements.

The provider must:

All staff required to chaperone patients must have a DBS check in place. In addition to this a record should be kept to explain the decisions that have been informally made in relation to staff not having a criminal record check using the disclosure and barring service (DBS).

In addition the provider should:

An updated fire risk assessment should be undertaken.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requiring improvement for providing safe services.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

The practice had a good track record on safety. Emergencies including fire were planned for and all staff were aware of what to do if an emergency arose. However there was no updated fire risk assessment in place. Whilst the practice told us it had been undertaken they were not able to locate it, or describe the details within the assessment. The fire procedure in place did not identify who the trained fire wardens were and did not detail the elements of evacuating the building and ensuring the safety of the occupants. We spoke with staff about the fire procedure. Each person we spoke with were clear about their responsibilities should a fire occur.

There was effective recording and analysis of significant events to help ensure that lessons learnt were always shared among relevant staff. There were safeguarding measures in place to help protect children and vulnerable adults, however these processes required improvement as not all staff had received training in the protection of vulnerable adults and were not fully aware of the correct processes to follow.

Recruitment procedures and checks were mostly completed as required, to assess whether staff were suitable and competent. A risk assessment had not always been carried out when a decision had been made to omit a criminal records check (using the disclosure and barring service) on administration staff.

The practice was clean, tidy and hygienic. Suitable arrangements were in place to maintain the cleanliness of the practice. There were systems in place for the retention and disposal of clinical waste. However one clinical area, the nurse treatment room, needed updating to help ensure infection control good practice was upheld.

Are services effective?

Good

The practice is rated as good for providing effective services. There were systems in place to ensure that treatment was delivered in line with best practice standards and guidelines.

Summary of findings

The practice had a clinical audit system in place and audits had been completed. We saw that care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice.

There was evidence of multi-disciplinary working and the practice was taking part in an initiative to help patients remain at home and reduce the need for hospital admission.

Are services caring?

Good

The practice is rated as good for providing caring services. All the patients we spoke with during our inspection were very complimentary about the service. All the patients who completed a comment card in the weeks before our inspection were entirely positive about the care they received. We saw staff interacting with patients in a caring and respectful way.

Staff were motivated and inspired to offer kind and compassionate care and put significant effort in to providing care that took account of each patient's physical support needs and individual preferences. Patients were involved in planning their care and making decisions about their treatment and were given sufficient time to speak with the GP or nurse. Patients were referred appropriately to other support and treatment services.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had good facilities and was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Evidence showed that the practice responded quickly to issues raised and learned from patients' experiences, concerns and complaints to improve the quality of care.

The practice recognised the importance of patient feedback and had an active patient participation group (PPG) to gain more patients' views.

Summary of findings

Are services well-led?

The practice is rated as good for being well-led.There was a strong leadership with a clear vision and purpose, and all staff were aware of the practice's stated mission. Governance structures were robust and there were systems in place to manage risks.

Good 

Summary of findings

The six population groups and what we found

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

Older people

Good

Townsend House is rated as good for the care of older people. Care was tailored to individual needs and circumstances. There were regular care reviews involving patients, and their carers where appropriate. Treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery of, for example, palliative care for older people approaching the end of life. This included working with a community matron for older patients in the community.

The practice regularly reviewed older patients to help them remain at home and reduce the need for admission to hospital. Older patients had a named GP responsible for their care. The GPs worked effectively with consultant geriatricians for advice on the best treatment and support for older patients.

The practice had a designated GP for each care home in the area, fostering closer working relationships and allowing routine reviews of these patients. They also maintained a low average list size allowing delivery of patient centred care and more time to be spent with each patient. The practice had established a local palliative care service with the League of Friends who provided transport and another local GP practice, who provided hands on end of life care for patients.

People with long term conditions

Good

Townsend House is rated as good for the care of people with long term conditions. The practice identified patients who might be vulnerable, including those with multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. The staff at the practice maintained links with external health care professionals for advice and guidance about particular long term conditions, such as diabetes and asthma.

Patients with long term conditions had tailor-made care plans in place. Patients were pleased with the care they received for their long term conditions and were offered clinics at a time convenient to them for monitoring and treatment of conditions. These included diabetes, heart failure, hypertension, high cholesterol, renal failure, asthma and chronic respiratory conditions. The nurses took a lead role in particular conditions and attended educational updates to make sure their knowledge and skills were up to date.

Summary of findings

Appointments were available for patients with asthma and chronic lung disorders. The practice used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients.

Patients were supported with weight management and referrals to dieticians were made where appropriate.

Specific appointments were made which supported and treated patients with diabetes; they included education for patients to learn how to manage their diabetes through the use of insulin. Health education about healthy diet and life style for patients with diabetes was provided. The practice also held a virtual diabetic clinic with two other GP practices and a hospital diabetic consultant. This is a time where patients with complex needs could be discussed confidentially with the specialist, and GPs received education on the management of patients with complex cases.

Home visits and medication reviews were provided by GPs, for patients with long term conditions who had been recently discharged from hospital.

The practice used a specific computerised patient record system allowing out of hours service providers to access information about specific patients, this helped promote continuity of care and treatment, providing a more seamless service for the patient. The practice's GPs and the out of hours service GPs were then aware of any treatment that had been given to patients with long term conditions, or those at the end of their life.

There were above average numbers of nurse appointments made available to ensure they had capacity for these patients and where patients were unable to access the practice, they were seen at home. The practice worked closely with the community matron and had weekly multidisciplinary team meetings with the wider social care team to ensure that support networks were in place, particularly with regard to anticipatory care planning. All patients were reviewed regularly by their registered GP. The practice was adaptable and offered all patients with mobility issues appointments at their branch practice in Beer, where access was easier.

Families, children and young people

Townsend House is rated as good for the care of families, children and young people. Parents we spoke with were very happy with the care their families received.

Good

Summary of findings

There were well organised baby and child immunisation programmes available to help ensure babies and children could access a full range of vaccinations and health screening.

The practice had effective relationships with health visitors and the school nursing team, and were able to access support from children's workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening. The practice referred patients and worked closely with a local family and child service to discuss any vulnerable babies, children or families. In response to feedback from patients with families and those with school age children the practice had set up a minor illness service to ensure same day access for patients with new problems. The practice also extended the opening hours to improve access and had daily phone call surgeries for patients who did not need face to face appointments. One named GP met with the health visiting team on a quarterly basis to review all patients on the joint case load but also met them more frequently if needed.

Men, women and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Working age people (including those recently retired and students)

Good

Townsend House is rated as good for the care of patients who were of working age or who had recently retired and students.

Advance appointments, including early morning and evening appointments were available twice a week to assist patients not able to access appointments due to their working hours.

There was a well-established patient participation group at the practice who demonstrated that they were constantly striving to recruit new members of working age.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available. Pneumococcal vaccination and shingles vaccinations were provided for patients at risk, either at the practice during routine appointments or at weekends for patients who found it difficult to access the practice during office hours.

The staff carried out opportunistic health checks on patients as they attended the practice. This included offering referrals for smoking

cessation, providing health information, routine health checks and reminders to have medication reviews. The practice also offered age appropriate screening tests, examples included testing for prostate cancer and cholesterol testing.

Patients who received repeat medications were able to collect their prescription at a pharmacy of their choice. The practice had an electronic prescribing system in place which sent the approved prescription directly to the chosen pharmacy. This was useful for patients who could not easily access the practice during office hours.

People whose circumstances may make them vulnerable

Good

Townsend House is rated as good for the care of people whose circumstances may make them vulnerable. There were no barriers to patients accessing services at the practice. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation.

Staff were trained in how to help patients who did not have a permanent address in the area, whether as temporary residents, migrant workers or the homeless and traveller populations. They were clear on the processes in place for the patient to register as a temporary patient.

Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

Practice staff were able to refer patients with alcohol or drug addictions to an alcohol/drug service for support and treatment.

People experiencing poor mental health (including people with dementia)

Good

Townsend House is rated as good for the care of people experiencing poor mental health (including people with dementia). Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with serious mental illnesses. GPs had the necessary skills and information to treat or refer patients with poor mental health.

The practice employed a carer support worker one day a week who is pivotal in supporting carers and particularly where patients were affected by dementia. We saw evidence that showed patients valued this service and saw the practice were proactive in keeping updated with the latest information and advice available.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection. We spoke with one representative of the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 24 comment cards which contained detailed positive comments.

Comment cards stated that patients were grateful for the caring attitude of the staff and for the staff who took time to listen effectively. Comments also highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG representative. The feedback from patients was wholly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, very satisfied and said they got good treatment. Patients told us that the GPs were excellent.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients appreciated the service provided and told us they had no complaints and could not imagine needing to complain.

Areas for improvement

Action the service MUST take to improve

All staff required to chaperone patients must have a DBS check in place. In addition to this a record should be kept to explain the decisions that have been informally made in relation to staff not having a criminal record check using the disclosure and barring service (DBS).

Action the service SHOULD take to improve

An updated fire risk assessment should be undertaken.

Outstanding practice

Specific appointments were made which supported and treated patients with diabetes; they included education for patients to learn how to manage their diabetes through the use of insulin. Health education about healthy diet and life style for patients with diabetes was provided. The practice also held a virtual diabetic clinic with two other GP practices and a hospital diabetic consultant. This is a time where patients with complex needs could be discussed confidentially with the specialist, and GPs received education on the management of patients with complex cases.

Townsend House Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Townsend House Medical Centre

Townsend House provides primary medical services to people living in the town of Seaton and the surrounding areas.

At the time of our inspection there were approximately 6200 patients registered at the service with a team of three GP partners. GP partners held managerial and financial responsibility for running the business. In addition there were three part time salaried GPs, three registered nurses, two healthcare assistants the practice manager, and additional administrative and reception staff. There was a good gender mix at the practice with three male GPs and three female GPs enabling patients more choice as to who they would like to see.

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

Townsend House is open between Monday and Friday 8am – 6pm. Outside of these hours patients are directed to an Out of Hours service delivered by another provider.

Routine appointments are available daily and are also bookable in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Why we carried out this inspection

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

How we carried out this inspection

Before conducting our announced inspection of Townsend House Practice, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

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

We carried out our announced visit on Tuesday 14 October 2014. We spoke with six patients and eight staff at the practice during our inspection and collected 24 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, four general practitioners, (GPs) receptionists/clerical staff, practice

Detailed findings

nurses, and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with a representative from the patient participation group (PPG).

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

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

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

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

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

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

Are services safe?

Our findings

Safe Track Record

The practice was able to demonstrate that it had a good track record on safety. The practice manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents. We saw that the practice kept separate records of clinical and non-clinical incidents and the manager took all incidents into account when assessing the overall safety record.

There were clear accountabilities for incident reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents. We saw how the practice manager recorded incidents and confirmed that they were investigated. Safety alerts were shared and discussed with all staff as they received.

Learning and improvement from safety incidents

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

The practice kept records of significant events that had occurred during the last year and these were made available. A slot for significant events was on the weekly practice meeting agenda and a dedicated meeting occurred six monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary 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 these staff told us they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

All staff had received relevant updated training on safeguarding children, however not all staff had received updated training on safeguarding adults. The practice told us that this had been booked for the near future. A named GP had a lead role for safeguarding older patients, young patients and children. They had been trained to the appropriate advanced level. An example was given to us of a recent safeguarding alert that had been made. A log containing records of this was made available to us. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies both in and out of hours. Contact details were easily accessible.

A chaperone policy was in place. Chaperone training had been undertaken by all nursing staff, including the Health Care Assistants. If nursing staff were not available to act as a chaperone, two receptionists had also undertaken training and understood their responsibilities whilst accompanying a patient during consultation, examination or treatment. GPs and nursing staff documented that a chaperone had been offered and either accepted (with name of chaperone) or declined by the patient, in the patient record. Despite this administrative staff had not undergone a DBS check and a risk assessment had not been carried out to qualify this decision.

Medicines Management

We checked the storage of refrigerated medicines and the medicines in the resuscitation trolley and found that they were stored appropriately. There was a clear policy for maintenance of the cold chain and action to take in the event of a potential failure. There were no controlled drugs were kept on site.

When nurses administered prescription only medicines, such as vaccines, patient group directions or patients specific directions were in place in line with relevant legislation. A member of the nursing staff was about to undertake a training course to become an independent prescriber.

The practice had a protocol for repeat prescribing which was in line with General Medical Council guidance. This covered how staff that generated prescriptions were trained, how changes to a patient's repeat medicines were managed and the system for reviewing repeat medicines to ensure they remained necessary and without contra-indications. Blank prescriptions were stored securely.

The practice undertook a review of their prescribing every 6 months with the local pharmacist. The audit was with the pharmacy and the results were not yet available,but we were told it covered issues such as how many consultations had been undertaken and how many antibiotics had been prescribed.

Cleanliness & Infection Control

Are services safe?

We saw that the practice was clean. Patients we spoke with said they were satisfied with standards of hygiene at the practice. There were systems in place to reduce the risk and spread of infection. We observed and staff told us that Personal protective equipment was readily available and was in date. Patients confirmed that staff wore personal protective equipment when needed. Hand sanitation gel was available for staff and patients throughout the practice. We saw staff used this. There was hand washing posters above each wash hand basin throughout the practice including in the patients' toilet.

Clinical waste and sharps were being disposed of in safe manner. There were securely lidded sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored in a dedicated secure area whilst awaiting collection from a registered waste disposal company.

There were infection control policies in place and all staff we spoke to understood the importance of ensuring that the policies were always followed.

We saw one consulting room that was carpeted and had a sink with traditional type taps that could not be turned on or off with the elbows. The practice notified us 24 hours following the inspection to inform us that a new carpet and replacement taps were to be fitted within two weeks.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had an effective system using checklists to monitor the dates of emergency medicines and equipment which ensured they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

The practice had a low turnover of staff. The practice did not use locums as staff covered for each other during staff absence. Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures. Criminal records checks carried out by Disclosure and Barring Service (DBS) were only performed for GPs and nursing staff, not administrative staff. However, administrative staff said they were sometimes required to chaperone patients and had been trained to do so. No risk assessments were in place to qualify why a DBS check had not been undertaken.

The practice had clear disciplinary procedures to follow should the need arise. The nurses' Nursing and Midwifery Council (NMC) registration status was checked annually to ensure they were listed on the professional register and thus enabled each to practice legally as a registered nurse.

Monitoring Safety & Responding to Risk

There was a suitable business continuity plan that documented the practice's response to any prolonged period of events that may compromise patient safety. For example, this included a computer crash or loss and lists of essential equipment.

Nursing staff received medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

Arrangements to deal with emergencies and major incidents

There was a duty system in operation to ensure one of the nominated GP partners covered for their colleagues, for example to carry out emergency home visits, or checking blood test results. Appropriate equipment was available and maintained to deal with emergencies, including that used in the event of a patient or visitor collapse.

Staff explained that emergency procedures had been used successfully on a patient who had collapsed on the premises. Administration staff told us they appreciated that they had been included in the basic life support training sessions.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All the GPs and nurses we spoke with were able to describe and demonstrate how they access and use both guidelines from the National Institute for Health and Care Excellence and from local health commissioners.

We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. Whilst there was no formal policy for ensuring GPs and nurses remained up to date, all the GPs and nurses interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their individual needs assessed and care planned in accordance with best practice. The practice used computerised tools to identify patients with complex needs, and who have multidisciplinary care plans documented in their case notes.

The practice referred patients appropriately to consultants at acute hospitals, and also to community care services. We saw evidence of the appropriate use of two week wait referrals. We saw minutes from meetings where regular review of elective and urgent referrals are made, and that improvements to practise are shared with all relevant staff.

Management, monitoring and improving outcomes for people

The practice provided a service to up to 6261 patients. The practice were keen to ensure that staff had the skills to meet patient needs. For example, nurses had received extensive training including immunisation, diabetes care, cervical screening and travel vaccinations.

The practice routinely collected information about patient care and outcomes. The Quality and Outcomes Framework had been used to assess performance and regular clinical audit was undertaken, for example relating to the prescribing of antibiotics. The practice was able to demonstrate the changes made since the initial audit and these were minuted. Annual appraisal documents showed that all clinical staff were engaged in the audit process. Staff spoke positively about the culture in the practice around audit and quality improvement.

Effective staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed.

The practice was a teaching practice for new GPs. One of the GPs was a course organiser on the GP vocational training scheme and was a trainer for trainee GPs.

Nursing and administration staff had received an annual formal appraisal and kept up to date with their continuous professional development programme. We saw documented evidence to confirm that this process was carried out.

A process was in place to ensure clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for the role of each person.

The staff training programme was monitored to make sure staff were up to date with training the practice had made mandatory. This included basic life support, safeguarding, fire safety and infection control. We saw that adult safeguarding needed updating, we were told this had been planned for the near future. Staff said that they could ask to attend any relevant external training to further their development.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

We found that the practice worked with other service providers to meet patient needs and manage those with more complex care and treatment.

Blood results, X ray results, letters from hospital, and outpatients and discharge summaries, out of hour's providers were received electronically. Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hour's services were seen and actioned by a GP on the day they had been received. Outpatient letters were reviewed in less than five days from receipt.

Are services effective?

(for example, treatment is effective)

The GP seeing documents and results was responsible for the action required and either recorded the action or arranged for the patient to be contacted and seen, depending on clinical risk.

Referrals were made using the Choose and Book service.

Information Sharing

The practice proactively identified patients who were also carers and offered them additional support. Staff were automatically alerted by a flag on patient records, to those who were also registered as carers. This ensured that GPs were aware of the wider context of the patient's health needs. The practice employed a carer support worker for one day a week who was pivotal in supporting carers. Appropriate referrals were made to other members of the multi-disciplinary teams when needed.

Consent to care and treatment

We saw examples of how young people, those with learning disability, those with mental health problems and those with dementia were supported to make decisions. The staff demonstrated a clear understanding of the Gillick competencies used to make decisions about patients under 16 years old giving their consent.

The nurse told us that she explained treatments and tests to patients before carrying out any procedures. Patients were given an explanation of what was going to happen at each step so that they knew what to expect.

Patients told us they felt that they had been involved in decisions about their own treatment and that the GP gave them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

We saw the practice's consent policy and its guide to the Mental Capacity Act 2005 (MCA). These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. GPs and nurses were aware of patients who needed support from nominated carers and ensured that carers' views were listened to as appropriate. Best interest meetings were held when a patient lacked capacity to make the decisions regarding their care themselves.

Health Promotion & Prevention

Health promotion literature was readily available to patients and was up to date. This included information about services to support them in smoking cessation schemes for instance. People were encouraged to take an interest in their health and to take action to improve and maintain it.

We saw that new patients were invited into the practice when they first registered to impart details of their past medical and family health histories. They were also asked about social factors including occupation, lifestyle and medications. This enabled the GPs and nurses to assess each new patient's health and risk factors.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed patients being treated with respect and dignity throughout our inspection.

Patients were given the time they needed to ensure they understood the care and treatment they required. Three patients we spoke with confirmed that they never felt rushed.

Privacy screens and window blinds were present in all clinical rooms. The nurse told us that these were always used and that the door was closed when patients had procedures carried out. The approach explained to us reflected the guidance in the practice policy. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Patients completed CQC comment cards to provide us with feedback. We received 24 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped maximise the privacy of patient information.

Staff told us if they had any concerns or saw any instances of discriminatory behaviour or that patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate, and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we saw showed patients responded positively to questions about

their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in their care decisions. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 82% of the 245 respondents in the 2013 survey stated that they were treated with consideration by their GP and 86% said they felt respected. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carer's checks were offered by the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs. The practice had a significant proportion of older people on its list so worked hard to accommodate their needs. For example by having pre bookable appointments as well as on the day appointments made available. They also offered a nurse led minor injury service so that people did not have to travel considerable distances to the nearest hospital. In addition the practice had a high home visit rate due to the demography, and routinely visited housebound patients, as well as operating village hall surgeries.

The practice building was purpose built. There was level access to the front door and automatic doors to assist patients with mobility problems or with children in push chairs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff said that no patient would be turned away.

The number of patients with a first language other than English was low and staff said they knew these patients and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

General access to the building was good. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. All of the consulting rooms had level access.

Access to the service

Patients could make appointments by phone or in person. The practice was open between 8am and 6pm and was not closed at lunch time.

Patients told us that it was usually easy to obtain a routine appointment. All the patients we spoke with told us that it was possible to get an urgent appointment on the same day if necessary.

The GPs each had their own patient list. These patients were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

A 2013 national patient survey showed that 71% of the respondents rated their experience of getting an appointment as good or very good. This is higher than the national average.

Listening and learning from concerns & complaints

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

There was a complaints process publicised in the waiting room, on the practice web site and in the practice leaflet. Patients we spoke with had not had any cause to complain but they believed any complaint they made would be taken seriously.

We saw the practice's log and annual review of complaints received. The review recorded the outcome of each complaint and identified where learning from the event had been shared at a practice meeting.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff knew and understood the vision and values and knew what their responsibilities were in relation to these.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group, many staff had worked at the practice for many years and were positive about the open culture within the practice.

We saw that the staff performance monitoring system was used as much to recognise and reward good performance as to identify any potential underperformance. All the staff we spoke with said they felt valued and respected by the practice manager. There were regular practice meetings, although administrative staff told us they felt more comfortable raising issues with the practice manager in private, rather than speaking up during meetings.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice. Any clinical or non clinical issues were discussed amongst staff as they arose. For example GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. These issues were then followed up more formally at six monthly clinical meetings where standing agenda items included significant events, near misses, complaints, health and safety and complaints.

The practice used the Quality and Outcomes Framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. In addition to the incentive led audits there was a real sense that GPs wanted to perform audits to improve the service for patients and not just for their own professional revalidation requirements or QOF scores.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 8 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

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

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

Patients we spoke with in the waiting room had not been formally asked for their views about the practice but they were aware there were suggestion boxes in the waiting room. The website encouraged patients to give feedback if they chose.

The practice had a patient participation group (PPG), which was well established. One PPG member who came to the inspection said the practice manager and GP representative were keen to encourage patient feedback and involvement.

Management lead through learning & improvement

There was standardised, formal, systematic processes followed to ensure that learning and improvement take place when events occur or new information provided. For example the practice hold six monthly meetings to discuss any current hot topics and review any new National Institute for Health and Clinical Excellence (NICE) guidelines and the impact for patients at the practice. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the

Are services well-led?

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

practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

There were environmental risk assessments for the building. For example, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building. Health and safety items were a standing agenda item for the three monthly clinical meetings. However the practice could not locate their fire risk assessment on the day of the inspection and although staff knew where to assemble and how to evacuate the building there were no set processes for individuals to follow.

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
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person must – (1) (a) operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character (b) Ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Patients and others were not fully protected against the risks associated with unsafe or unsuitable staff because the practice had not carried out criminal record checks for administration staff and the decision not to do so was not supported by a recorded risk assessment. Schedule 3 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement 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.