Axminster Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Axminster Medical Practice was inspected on Wednesday 1 October 2014. This was a comprehensive inspection.

The practice provides primary medical services to people living in the town of Axminster, Devon and the surrounding areas. At the time of our inspection there were approximately 11,120 patients. Approximately 5,500 patients live in Axminster town itself with the other 5,600 living in the surrounding villages. The practice area covers approximately 100 square miles.

The practice provides services to a diverse population age group and is situated in a town centre location.

The practice comprises of a team of nine GP partners, who hold managerial and financial responsibility for running the business. In addition there are three salaried GPs, four registered nurses, two nurse practitioners, three health care assistants, a practice manager, and 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.

The practice had a dispensary attached.

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, organised, with facilities and equipment to consult with, examine and treat patients. There were effective infection control procedures in place.

The practice valued feedback from patients and acted upon this. Feedback from patients about their current care and treatment was consistently positive. Staff portrayed 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.

Patient's needs were assessed and care planned and delivered in line with current legislation. This included assessment of patients' mental capacity to make decisions about their care and treatment, and the promotion of good health.

Recruitment, pre-employment checks, induction and appraisal processes were in place. Staff had received training appropriate to their roles and further training needs had been identified and planned.

Statistical data analysis demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was performed and communicated amongst all staff.

We saw one area of outstanding practice:

The practice provided carers with health and wellbeing checks, these detailed health checks were followed by a discussion session on a one to one basis with the carer about their needs and what other services may be available to them. The practice had a representative from an established local carers group who visited the practice once a month to augment this service. Carers were encouraged to contact the surgery at any time and were routinely followed up every six months.

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

Importantly, the provider should:

Ensure that there is a record of the distribution of blank loose leaf prescriptions.

Ensure that a standard operating procedure is in place for the safe storage and use of liquid Nitrogen.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Significant events were analysed and recorded 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.

The practice had a good track record on safety, however there were two areas where it should make improvements. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough, this related to the storage of liquid nitrogen and the safe storage of prescription pads.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent.

The practice was clean, tidy and hygienic. Systems were in place to maintain the cleanliness of the practice to a high standard. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data obtained both prior to and during the inspection showed the practice had systems in place to make sure the practice was effectively run.

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

Supporting data showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation of professional qualifications had been completed.

The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

Summary of findings

about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as outstanding for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Care was tailored to individual patient needs and circumstances. Patients were reviewed regularly by the GPs and nurses to promote their health and independence and to help avoid the admission to hospital. There were regular patient care reviews involving patients, and their carers where appropriate.

People with long term conditions

Good

Axminster Medical Practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

Axminster Medical Practice is rated good for families, children and young people. The practice worked with local health visitors to offer a full health surveillance programme for children under the age of five. Checks were also made to help ensure the maximum uptake of childhood immunisations.

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held clinics twice a week. The midwives had access to the practice computer system and could speak with a GP if needed. Health visitors also held baby clinics at the community hospital and the practice had contact with the school nursing team. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

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

Summary of findings

Working age people (including those recently retired and students)

Good

Axminster Medical Practice is rated good for working age people. Patients who were of working age or who had recently retired were pleased with the care and treatment they received.

The practice offered extended opening times two days a week to provide easier access for patients who were at work during the day. Patients were offered a choice when referred to other services.

People whose circumstances may make them vulnerable

Outstanding

Axminster Medical Practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for them if required.

There were care homes for people with learning disabilities in the area. Annual health checks were offered to these patients in their own homes and for those living in care homes. Vaccinations were offered when required and managed safely. Appropriate arrangements were in place to facilitate access to care for patients with mobility limitations.

The practice provided carers with health and wellbeing checks, these detailed health checks were followed by a discussion session on a one to one basis with the carer about their needs and what other services may be available to them. The practice had a representative from an established local carers group who visited the practice once a month to augment this service. Carers were encouraged to contact the surgery at any time and were routinely followed up every six months.

People experiencing poor mental health (including people with dementia)

Good

Axminster Medical Practice was rated good for people experiencing poor mental health. The practice was tailored to patient 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 patients with poor mental health. They were also responsive in referring patients with mental health concerns to specialist services. Liaison was undertaken with external agencies, for example the mental health crisis team, local support groups and counsellors when required.

Summary of findings

What people who use the service say

We spoke with 21 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 29 comment cards which contained detailed positive comments.

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

These findings were reflected during our conversations with patients and discussion with the PPG representative. The feedback from patients was overwhelmingly positive.

Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received 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.

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

Patients found it easy to get repeat prescriptions and said they thought the website was good.

Outstanding practice

The practice provided carers with health and wellbeing checks, these detailed health checks were followed by a discussion session on a one to one basis with the carer about their needs and what other services may be available to them. The practice had a representative from an established local carers group who visited the practice once a month to augment this service. Carers were encouraged to contact the surgery at any time and are routinely followed up every six months.

Axminster Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a pharmacist inspector and an expert by experience.

Background to Axminster Medical Practice

The practice provides primary medical services to people living in the town of Axminster, Devon and the surrounding areas. At the time of our inspection there were approximately 11,120 patients. Approximately 5,500 patients live in Axminster town itself with the other 5,600 living in the surrounding villages. The practice area covers approximately 100 square miles.

The practice provides services to a diverse population age group and is situated in a town centre location.

The practice comprises of a team of nine GP partners who hold managerial and financial responsibility for running the business. In addition there are three salaried GPs, four registered nurses, two nurse practitioners, three health care assistants, a practice manager, and additional administrative and reception staff.

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

Axminster Medical Practice is open Monday to Friday from 8am-630pm. The practice also has late surgeries on Mondays and Thursdays until 730pm. Outside of these hours a service is provided by another health care provider, which patient's access by dialling the national service number.

Each GP has appointments each day that patients pre book up to eight weeks in advance. Appointments were also available to book on the same day with each GP to help ensure that patients who become unwell could be seen quickly. The GPs also have additional emergency appointments to deal with patients with very urgent health care needs. The practice also had a duty GP each week-day, to guarantee cover for any serious incidents or patient emergencies.

The GPs were responsible for prescribing medicines at the practice. The practice was a dispensing practice. A dispensing practice is where GPs are allowed to dispense the medicines they prescribe for patients who live remotely from a community pharmacy.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

Detailed findings

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

How we carried out this inspection

The inspection team carried out an announced inspection of Axminster Medical Practice on 1st October 2014. We spoke with 21 patients and 12 members of staff. We spoke with a member of the patient participation group (PPG) over the telephone. The purpose of a PPG is to comment on the overall quality of the service at the practice and to act as an advocate on behalf of patients when they wished to raise issues.

We observed how staff dealt with patients in person and over the telephone. We discussed patient care plans. We spoke with and interviewed a range of staff including GPs, the practice manager, the practice nurses, reception and administrative staff. We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice.

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 of safety. Records showed that performance had been consistent over time and where concerns had arisen they had been addressed in a timely way. 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. The practice manager recorded incidents and told us they ensured each case were investigated.

Learning and improvement from safety incidents

The practice has a system in place for the reporting, recording, monitoring and analysis of significant events (SEA). Records of significant events that had occurred were available. A weekly meeting was held to discuss any clinical significant events that had occurred, these were then followed up at a three monthly meeting to discuss any further actions and finalise any improvements needed. For example recently a blood test result was not returned to the practice and the patient had not enquired about it. When the patient came in for another appointment they were advised to have a repeat blood test, for which the result was abnormal. Whilst there was no way of knowing if the original test had been abnormal it was raised as a serious incident. The computer system had no way of identifying all samples sent and matching them with all results received. Previously the practice used to tell patients they would contact them if a result was abnormal, indicating that no news was good news. As a result of this incident the practice now give all blood test patients a slip of paper asking them to ring in for their results after 2pm each day. The practice still initiates contact if the bloods results are abnormal but now ask that every patient rings in to check.

The practice manager received details of any medicines alerts from the medicines and healthcare products regulatory healthcare authority (MRHA). This information was passed on to practice's dispensary staff to check and take appropriate action. Records were kept of any errors made in the dispensary. Any errors, and the action taken to prevent further occurrences, were discussed in the regular staff meetings, for which minutes were kept.

Reliable safety systems and processes including safeguarding

All staff had received relevant training in safeguarding. A training record was seen which showed this. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

A chaperone policy was in place and was visible in the waiting room. Chaperone training had been undertaken by all nursing, healthcare and some administration staff. Staff were able to describe what their duties were should they need to chaperone a patient.

There were environmental risk assessments for the building. For example annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building.

Medicines Management

The practice had a dispensary attached, which provided dispensing for people who live further than a mile from a pharmacy. We looked at all the areas in the practice where medicines were stored. We also spent time in the dispensary talking to staff, looking at records and observing patients collecting their medicines. The dispensary was well ordered and working calmly, with sufficient staff available.

Two refrigerators were available in the dispensary for storing medicines. The temperature of these refrigerators was checked and recorded daily. Records showed these were within the safe range for storing medicines. However staff had not checked or recorded the daily minimum and maximum temperatures to demonstrate these refrigerators were always at the correct temperature. Staff made an amendment to include this in future records. The practice informed us the next day that this had been undertaken and improvements made.

Are services safe?

Nursing staff were responsible for the ordering of vaccines for the practice. Vaccines were stored in two dedicated locked refrigerators in the main part of the practice. We saw warnings next to the plugs to remind staff the refrigerators contained vaccines and must not be switched off. Records of the daily temperature for one new refrigerator showed this was kept at a safe temperature for storing vaccines. The second refrigerator temperature was also within safe limits however records did not reflect this as staff had omitted to reset the thermometer after frequent opening of the refrigerator door. We brought this to the attention of the practice manager, who told us that they would investigate this. The practice manager informed us the next day that this had been undertaken and improvements made.

The practice held stocks of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. Standard procedures were in place that set out how they were managed. These were followed by the practice staff. For example controlled drugs were kept in a controlled drugs safe. Access to them was restricted and the keys held securely.

Systems were in place for patients to order repeat prescriptions. Dispensary staff generated the prescriptions which were checked and signed by the doctor before patients were given their medicines.

Dispensed prescriptions waiting collection were stored neatly so patient's names were not visible to people in the waiting area. We heard staff checking with patients to make sure they were given the correct medicines. Patients who were not using the practice dispensary could collect their medicines directly from their choice of pharmacy.

Stocks of blank prescriptions were stored securely in the dispensary. However the arrangements for recording the distribution of some blank prescriptions were inadequate. We also noted that some blank prescriptions could be accessed by any member of staff or patients in a number of areas in the practice.

A range of standard operating procedures were in place for dispensary staff to follow. These were regularly reviewed.

Dispensing staff working at the practice had received training to undertake dispensing tasks. The practice manager told us she checked staff training certificates when these were awarded. Staff had an annual appraisal.

Cleanliness & Infection Control

Patients said the practice was always very clean. There was an infection control policy and a dedicated infection control lead who attended up to date training. There was guidance on infectious diseases for staff to access should a patient present at the practice. This gave guidance of when staff need to report infections to relevant agencies.

The treatment and consulting rooms appeared very clean, tidy and uncluttered. We saw that staff all knew where items were kept and worked in a clean environment. The clinical rooms were stocked with personal protective equipment (PPE) which included a range of disposable gloves, clinical cleaning wipes, aprons and coverings, which staff used. This reduced the risk of cross infection between patients. Within communal areas, for example the public toilets, hand washing guidance and paper towels were available.

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

Staff were clear about their responsibilities in relation to infection control. For example, all staff knew who the lead for infection control was, knew where to find policies and procedures and were aware of good practice guidance. Nursing staff were responsible for managing clinical spillages and had spillage kits available for use. Infection control audits were undertaken. The most recent audit undertaken identified that the use of disposable curtains in the treatment rooms would be good practice. These were purchased and were in use.

Equipment

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

A container of liquid Nitrogen was kept in the dispensary with protective equipment for staff to use. The practice

manager told us that only the GPs using this for specific clinics were allowed to make transfers to a carrying container. However there was no standard operating procedure or risk assessment in place for this process to make sure this was always managed safely.

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

Portable appliance testing (PAT), where electrical appliances were routinely checked for safety annually, was last carried in 2013.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. The practice said they used locums as staff cover but tried to use the same one for continuity. GPs told us they also covered for each other during shorter staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were in place and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal records checks were performed for GPs, nursing staff and all administrative staff.

The practice had clear disciplinary procedures to follow should the need arise.

The registered nurses Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were listed on the professional register, to enable them to legally practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had 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 computer loss and lists of essential equipment.

Nursing staff received any 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

Appropriate equipment was available to deal with an emergency, for example if a patient should collapse. The staff we spoke with all knew where to easily locate the equipment and emergency medicines. The emergency equipment was well maintained and effective checks were in place to ensure emergency medication and equipment did not expire. All staff, including administration staff had received training in emergency procedures.

The practice had a small supply of medicines for emergency use. Records showed these were checked regularly to make sure they were safe to use. Records were also kept of the contents of GP emergency bags and monitored by staff to make sure they remained safe to use.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used national institute for health and clinical excellence (NICE) guidance to ensure the care they provided was based on latest evidence and was of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw that any revised NICE guidelines were identified and shared with all GPs and nurses appropriately. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the NICE guidance and had formal meetings to discuss the latest changes to the guidance. We saw that where required, guidance from the Mental Capacity Act (2005) had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided.

The GPs and nurses we spoke with confidently described the processes to ensure that written informed consent was obtained from patients whenever necessary. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure. GPs and nurses were aware of the requirements of the Mental Capacity Act (2005) used for adults who lacked capacity to make specific decisions. They also knew how to assess the competency of children and young people to make decisions about their own treatment, using nationally recognised principles and guidance.

We saw that the practice was suitably equipped with the necessary equipment to help GPs and nurses investigate and diagnose the typical range of conditions patients might present with. The equipment was in good order and there was evidence that it had been regularly recalibrated as required.

Some patients were supplied with their medicines in a weekly compliance aid to help them take their medicines safely. Staff told us the GP assessed whether this would be appropriate.

Management, monitoring and improving outcomes for people

The practice were keen to ensure that staff had the skills to meet patient's needs. For example, nurses had received extensive training including immunisation, diabetes care, cervical screening and travel vaccinations.

The practice have instigated a major change in the way older people are cared for in the community and in secondary care. The key aim is to keep people at home with support from other members of the primary healthcare team. There is a scheme involving an early intervention service that utilised a "red telephone" to access rapid assessment of frail elderly in their own homes within 2 hours via a multidisciplinary team coordinated in Seaton.

GPs at the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation of their professional qualifications and personal learning purposes.

Effective staffing

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

Are services effective?

(for example, treatment is effective)

completed. Nursing and administration staff received an annual formal appraisal and kept up to date with their continuous professional development programme.

There were effective staffing and recruitment policies to ensure staff were recruited and supported appropriately. Paper and computer staff records demonstrated that staff had been recruited and employed in line with the practice policy. Before staff were appointed there was evidence that relevant checks had been made in relation to identity, registration and continuous professional development.

Staff told us they all received an annual appraisal and attended regular staff meetings to enable information sharing. Nursing staff received clinical supervision from the GP partners and with the GPs meeting informally to discuss clinical issues and diagnoses. All staff told us they had access to training related to their roles. Staff were alerted by the practice manager to concerns about faulty equipment from MHRA alerts. Patients were treated effectively by informed staff.

All the staff we spoke with told us they felt well supported by the GPs and nursing team as well as by the practice manager and each other. Patients told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with colleagues and other services

The practice had effective working arrangements with a range of other services such as the community nursing team, the local authority, local nursing and residential services, the hospital consultants and a range of local and voluntary groups.

The practice was involved in various multidisciplinary weekly meetings involving palliative care nurses, health visitors, social workers and district nurses to discuss vulnerable patients at risk, those with complex health needs, and how to reduce the number of patients needing hospital admission. The lead GP for safeguarding children attended monthly multidisciplinary meetings with the school nurse, health visitors and midwives to discuss patients on the child protection register and other vulnerable children. The discussions were minuted. This enabled the practice to have a multidisciplinary approach which ensured each patient received the appropriate level of care.

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

Information Sharing

The practice proactively identified people including carers who may have needed on-going support. New patients were offered a consultation to ascertain details of their past and medical and family history.

Consent to care and treatment

Staff were aware of the Mental Capacity Act (2005). For example they described how they recorded requests around resuscitation.

When patients did not have the capacity to make decisions, the nurses we spoke with described the process by which best interest decisions were made. The nurses also described and gave a clear understanding of the Gillick competencies which set out principles to follow regarding consent from patients under 16 years of age.

We saw how consent to treatment was recorded (both on the computer and sometimes written consent was obtained) when a minor operation was being undertaken. A clinical audit had been undertaken in September 2013 and it was found

Are services effective?

(for example, treatment is effective)

that consent had not always historically been recorded. Systems were put in place to address this and at the review of this audit in April 2014 it was found that 100% of patients had their consent recorded.

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, for instance, smoking cessation schemes. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

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.

New patients were invited into the surgery when they first registered, so that details of their past medical and family health histories could be recorded. They were also asked about social factors including occupation, lifestyle and medicines. This enabled the GPs and nurses to assess a new patient's risk factors.

GPs and nurses were automatically alerted to patients who were also registered as carers. This helped GPs awareness of the wider context of the patient's health needs. Carer's checks were undertaken by the nurses who provided additional practical and emotional support.

All patients with a learning disability had been offered a health check in the past twelve months. These were undertaken either at the practice or in the patient's home.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed patients being treated with respect and dignity throughout our day at the practice. The nurse displayed a positive attitude towards the patients and explained to us the support given to patients to make sure those referrals to specialists or for specific tests were followed through. The nurse also told us about their role in providing education to help ensure that patients understood and followed the advice given, after they left the practice.

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. We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 29 completed cards which contained very detailed positive comments. All comment cards stated that patients were happy with the service they received.

A privacy and dignity policy was in place and all staff had access to this. Disposable privacy screens and window blinds were present in most clinical rooms; we saw that the doors to clinical rooms were locked when a nurse was undertaking a procedure with a patient. The approach explained to us reflected the guidance in the practice policy.

Bereaved family members were offered the opportunity to speak with the GP or nurse whenever they felt they'd like to. A counselling service was also available, with a counsellor who visited the practice regularly.

Care planning and involvement in decisions about care and treatment

The patient survey information showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, they 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 informed decisions 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, 85% of the 282 respondents in the 2013 survey stated that they were treated with consideration by their GP and 87% 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 were responsive to patient needs. The practice had instigated a major change in the way frail older patients are cared for in the community and in secondary care, with the key aim to enable patients to remain at home, with support from other members of the primary healthcare team, rather than need admission to hospital.

The practice provided carers with health and wellbeing checks, these were comprehensive health checks, followed by a discussion session on a one to one basis with the carer about their needs and what other services may be available to them. The practice had a representative from a local carers group who visited the practice once a month to augment this service. Carers were invited to contact the surgery at any time but are routinely a follow-up appointment every six months.

We received positive feedback from patients about the clinical care and professionalism they had received from GPs and nurses.

Patients felt they were involved in their care and treatment. They confirmed they had time to think about their options and felt able to ask questions if they were unsure about anything. Patients were offered additional information about their illness and other help and advice.

Practice staff cared for patients with long term conditions including asthma, diabetes, and heart disease. They also provided child immunisation, travel vaccinations and phlebotomy (the process of taking blood). Maternity services were provided by the GPs and the locality midwifery team.

Nursing staff told us they took every opportunity to monitor a patient's health. They used routine appointments to monitor patients with long term conditions as well as having dedicated days specific to different conditions, for example diabetes. They said this had improved and increased patient access and choice about when they attended appointments.

Systems were in place to make sure urgent and routine referral letters were triaged, written and sent promptly. There were also systems in place to follow up on, for example, blood tests, x-rays and scans, and letters from the hospital. Patients were able to request appointments with the same GP unless it was an emergency and their preferred GP was not available. Continuity of patient care was enhanced by seeing the same GP, whenever it was possible.

Patients being referred to hospital were supported to choose a hospital or service that met their preference. The practice had good links between the hospital and community services which enabled swift referrals.

The practice actively engaged with commissioners of services, local authorities and other health care professionals to provide coordinated and integrated pathways of care that met patients' needs.

There had been a new patient participation group (PPG) set up. Members of this group were keen to become involved at the practice and told us they met monthly. They had already been working on a new patient survey. The PPG members said they were encouraged to contribute suggestions.

Tackling inequity and promoting equality

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

The number of patients with a first language other than English was very low and staff said they knew these patients well 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. The consulting rooms were on both the ground and first floors and there was a passenger lift providing level access.

Access to the service

Patients told us if they needed to see a GP there were urgent and emergency appointments available on the same day. Patients were able to book appointments by telephone or the practice online appointment service. The practice opening hours were clearly displayed in the practice and on their website and patient information

Are services responsive to people's needs?

(for example, to feedback?)

leaflet. If patients required GP assistance out of practice hours then details of who to contact were clearly displayed in the practice, on their website and in the practice information leaflet.

Most patients, especially younger people, were not worried which GP or nurse they saw, but those with complicated and/or long-term conditions usually tried to see their preferred GP. These patients were appreciative of the reception staff and told us they really helped patients who were regular and known to them.

Patients told us they were happy with the appointment system. They made and contacted the practice easily for an appointment, were given an appointment when needed and often saw their GP of choice. Patients said they sometimes there appointments were late but were informed if there was a delay on the automated check in. Other patients told us the reception staff did not inform them if there was a considerable delay.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their 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 on the day 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 it 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 and were positive about the open culture within the practice.

Staff said they communicated informally through day to day events and more formally though meetings and formal staff appraisal. They felt this worked well and that individual voices were heard and listened to.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. There were clearly identified lead roles for areas such as medicines management, complaints and incident management, and safeguarding. The responsibilities were shared between the GPs, the nurse and the practice manager.

Leadership, openness and transparency

Staff communicated a very clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a lead GP for safeguarding. Staff spoke about effective team working, clear roles and responsibilities but within a supportive organisation. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Staff were aware of where to find these policies if required.

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

The practice had a patient participation group (PPG), which had been set up earlier in the year. The PPG member who we spoke with said the practice manager and GP representative were keen to encourage patient feedback and involvement. The PPG said they had already been involved in sending out the next patient survey.

The practice used an independent company to carry out an annual survey of its patients. One of the benefits of this was that it enabled the practice to compare its performance with other practices. In February 2013 there were 282 patients who responded to the survey. The results showed that the practice was close to or above the national benchmark in all of 28 key indicators. These included all aspects of the practice, from staffing to the environment and care given.

Management lead through learning & improvement

We saw evidence that learning from significant events took place and appropriate changes were implemented. There were systems in place for the practice to audit and review significant events and action plans were put in place to help to prevent them occurring again.

There was a standardised, formal process followed to ensure that learning and improvement took place when events occurred or new information was to be shared. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.