Dr Kieran McCormack

Quality Report

Worthen
Shrewsbury
SY5 9HT
Tel: 01743 891401
Website: www.worthenmedicalpractice.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Dr. Kieran McCormack's practice, also known as Worthen Medical Practice on the 26 November 2014. We inspected this practice as part of our new focused, comprehensive, inspection programme.

We looked at how well the practice provided services for specific groups of patients. These included; older patients, patients with long-term conditions, families, children and young people, working age patients (including those recently retired and students), patients living in vulnerable circumstances and patients experiencing poor mental health (including people with dementia).

The overall rating for this practice was good.

Our key findings were as follows:

- There was a clear management structure to support and guide staff to deliver safe, responsive and effective care to patients.
- We found the leadership team was visible. There were good governance and risk management measures in place.
- Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.
- The practice provided patients with same day appointments and extended evening appointments every Monday.
- The practice took time to listen to the views of their patients and had an effective, active Patient Participation Group and any actions identified were implemented and used to improve the service.
- Staff had implemented a system to reduce the risk of patients missing their regular reviews for conditions, such as diabetes, respiratory and cardiovascular conditions.
- The practice was working towards the development, agreement and funding for new practice premises in the future. This had been widely consulted on over a ten year period.

Summary of findings

- The practice had an in house community care co-ordinator.
- Following home visits, the GP provided an individual medicine dispensing service where necessary for patients that required it.

We saw several areas of outstanding practice including:

- The practice staff were involved with supporting the Compassionate Communities initiative (Co Co). Staff recruited volunteers and co-ordinated support for individuals the impact of which was to improve people's wellbeing. This is a voluntary organisation that provides support for local people at home, helping them maintain their independence.

However, there was also an area of practice where the provider needs to make improvements.

The provider should:

- Complete a risk assessment in respect of the dispensary security.

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 good for safe.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents. Lessons were learned and communicated widely to all staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people patients safe. The practice had not completed a risk assessment in respect of their dispensary security arrangements.

Are services effective?

Good

The practice is rated good for effective.

Data showed the patient outcomes were at or above average for the locality. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had systems in place for appraisal and personal development of staff.

There was evidence that strong MDT working arrangements were in place. Systems were in place to ensure that clinicians were up to date with both the National Institute of Clinical Health and Excellence (NICE) guidelines and other locally agreed guidelines. We also saw that these guidelines were positively influencing and improving practice and outcomes for patients.

The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice staff were involved with supporting the Compassionate Communities initiative (Co Co). Staff members recruited individual volunteers and co-ordinated support for individuals the impact of which was to improve people's wellbeing. This is a voluntary organisation that provides support for local people at home, helping them maintain their independence. They provide a befriending service for potentially isolated or unsupported people to assist them to stay connected socially with friends or with local activities.

The practice GP and staff were involved and engaged with the Patient Participation Group (PPG) to ensure they were effectively

Summary of findings

meeting the needs of their registered population. The PPG assisted the practice by ensuring patients had access to the most up to date local information regarding a variety of local support groups and social meetings and initiatives.

Following home visits, the GP provided an individual medicine dispensing service where necessary for patients that required it.

Are services caring?

Good

The practice is rated as good for caring.

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. The practice had arrangements in place to offer patients/carers support to cope emotionally with care and treatment, for example, the compassionate communities service, local support groups and staff support. We saw that staff treated patients with kindness and respect, ensuring confidentiality was maintained. The practice provided patients with same day appointments and extended evening appointments every Monday. The practice took time to listen to the views of their patients and had an effective, active Patient Participation Group and any actions identified were implemented and used to improve the service. The staff at the practice and the PPG actively encouraged patient participation and involvement with community led initiatives to assist in improving patients' health, social interaction and their well-being.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice reviewed the needs of their local population and engaged effectively with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to appointments. Appointments and open access surgeries were held each day. The practice had good facilities and was well equipped to treat patients and meet their needs. This had been widely consulted on over a ten year period. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for well-led.

The practice had a clear vision which had quality and safety as its top priority. The strategy to delivery this vision had been produced

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with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. The practice planned for succession. We found a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients which included use of technology. The practice had an active patient participation group (PPG) with strong links to the local community and various forums included information about local social and health improvement activities. We saw future prospective plans regarding the practice premises and evidence of engagement and involvement with the local community which was led by the GP. The GP encouraged practice staff and engaged with the PPG and the local community to participate in driving forward local health and social care improvements.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

The practice offered proactive personalised care to meet the needs of patients and had a range of enhanced services, for example end of life care. The practice had signed up for the enhanced service (ES) to provide a 'Proactive Care Program' in which patients with complex needs were reviewed each month at multi-disciplinary team meetings including end of life palliative care meetings. Avoiding Unplanned Admissions enhanced service (ES) is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission including older people. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice staff were involved with supporting the Compassionate Communities initiative (Co Co). Staff members recruited individual volunteers and co-ordinated support for individuals the impact of which was to improve people's wellbeing. This is a voluntary organisation that provides support for local people at home, helping them maintain their independence. They provide a befriending service for potentially isolated or unsupported people to assist them to stay connected socially with friends or with local activities.

A Joint Strategic Needs Assessment (JSNA) is an on-going process by which local authorities, Clinical Commissioning Groups (CCG) and other public sector partners jointly describe the current and future health and wellbeing needs of its local population and identify priorities for action. According to the JSNA figures the percentage uptake of flu vaccination in people aged 65 and over in Shropshire was 72.8%, which was lower than the national target of 75% and the England average (74%) in the 2011-12 flu season. We saw that Dr Kieran McCormack's practice had achieved 82% flu vaccination uptake to date in 2014. In the over 65's the practice percentage uptake for the Pneumococcal vaccine was 86%. Pneumococcus is a bacterium which can cause pneumonia, meningitis and some other infections. The practice had also been very successful in the 70 and 79 year old uptake of the shingles vaccine having achieved 100% in both age groups in 2013.

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People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions (LTC).

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Longer appointments and home visits were available if required. Systems were in place to carry out structured annual reviews to check patients' health and medication needs were being met. Where patients had complex health needs the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.

We found staff had implemented a system to reduce the risk of patients missing their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was consistently followed.

One staff member employed by the practice was an in house community care co-ordinator. The introduction of care co-ordinators based in GP practices was a CCG initiative, based on providing as much support through community settings, such as is possible to enable patients to live independently for longer. The practice staff were involved with supporting the Compassionate Communities initiative (Co Co). Staff members recruited individual volunteers and co-ordinated support for individuals the impact of which was to improve people's wellbeing. They are a voluntary organisation that provides support for local people at home, helping them maintain their independence. They provided a befriending service for potentially isolated or unsupported people to assist them to stay connected socially with friends or with local activities.

We saw that patient referrals, hospital letters, blood results and investigations were monitored and managed effectively to provide a seamless a service as possible to the patients.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

The practice met regularly with the health visitor who held a monthly clinic at the practice. Systems were in place to highlight any vulnerable patients within the patients' electronic records.

We saw that the pregnant mothers' uptake of flu vaccinations was 100% in 2014 to date.

Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had achieved 100% uptake in MMR childhood immunisations.

The uptake of a cervical smear screening test in women over the age of 25 to October 2014 was 90%.

The practice informed us that the local NHS Trust launched a Family Nurse Partnership (FNP) Service this year, to provide home visiting support to teenage girls aged 19 years and under who are pregnant. This enabled the practice to refer to and liaise with a specially trained family nurse who would visit young mums regularly; from early in pregnancy until the child was two.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people (including those recently retired and students).

The percentage of patients within the practice population of working age (including those recently retired and students) was 58.4% of those registered at the practice.

Patients were able book appointments and request repeat prescriptions using on line services and the practice offered an open, same day appointment system with the GP and an extended hours service on Monday evenings. A range of health promotion and screening services were available which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances and would include homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and patients had received a follow-up. It offered longer appointments for people with a learning disability and the practice worked in conjunction with the local authority learning disability team to follow up on any non-attendance.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in

Summary of findings

vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice offered a minor injury service for both registered and non-registered patients including those in circumstances which may make them vulnerable.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for the population group of people experiencing poor mental health (including people with dementia).

Registers of people experiencing poor mental health were maintained and patients had annual health checks. Literature and information regarding access to local services was provided to patients and staff were aware of how to refer to and contact the local mental health crisis team.

A register of patients with a diagnosis of dementia was maintained by the practice and staff were proactive in ensuring they maintained details of carers or of named individuals who supported patients within the vulnerable patient groups.

The practice provided information to patients about how to access various support groups and voluntary organisations, including for example MIND. The Patient Participation Group (PPG) at the practice drew to patient's attention national and local initiatives through their publications and slides. This included for example in October 2014, World Mental Health Day with a focus on Living with Schizophrenia. It also provided contact details for local support groups such as Healthy Friendships group, who support adults who experience emotional distress by one to one befriending, club and group activity and through education, training and exposure to new cultural experiences. Local information was provided for a service called Rethink Shrewsbury Carers Support Group. This group offered information and support relating to mental health through publications, shared experiences and occasional speakers.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received 44 completed Care Quality Commission (CQC) comment cards and spoke with three patients. All were positive about the care and treatment they received. We received feedback from both male and female patients. Patients told us they felt listened to and involved in planning their care and treatment. They told us they were treated with dignity and respect.

All patients were extremely complimentary about the care provided by the clinical staff and the positive and friendly atmosphere fostered by all staff. They found the doctors, nurses and dispensary staff to be professional and knowledgeable about their treatment and care needs. Patients reported that the whole staff team treated them with dignity and respect. Patients informed us they appreciated and highly valued this practice.

The practice had a patient participation group which met regularly with the GPs and senior staff. Patient Participation Group (or PPG) – a group of patients registered with a practice who work with the practice to improve services and the quality of care. They informed us that the meetings were productive and effective, their views were listened to and where appropriate acted upon in a timely manner. They raised no concerns about the practice and informed us they found them to be responsive to local patients' needs. They told us that the staff were professional, approachable, and compassionate and staff treated patients as individuals.

The National GP patient survey results for Dr Kieran McCormack practice, published in July 2014 found that 98% of patients found it easy to get through to the practice by phone and 95% of patients would recommend the practice to someone new to the area. The percentage of patients who usually waited 15 minutes or less after their appointment time to be seen was 65% and 96% described their overall experience of the practice as good.

Areas for improvement

Action the service SHOULD take to improve

Complete a risk assessment in respect of the dispensary security.

Outstanding practice

The practice staff were involved with supporting the Compassionate Communities initiative (Co Co). Staff recruited volunteers and co-ordinated support for individuals the impact of which was to improve people's wellbeing. This is a voluntary organisation that provides support for local people at home, helping them maintain their independence.

Dr Kieran McCormack

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Dr Kieran McCormack

The Dr. Kieran McCormack practice is located in Worthen, Shropshire, and is part of the NHS Clinical Commissioning Group (CCG) Shropshire. The total registered patient population is 2,036.

The clinical staff team currently comprises of a male and female GP, a practice nurse who works 25 hours per week and a healthcare assistant (HCA). The HCA also carries out phlebotomy (blood taking) and NHS Health Checks for patients at the practice when requested to do so by the practice. The Lead male GP provides 8 sessions per week at the practice and salaried female GP provides 4 sessions.

The practice is a dispensing practice and employs a dispenser/ manager who is employed for 32 hours a week. Working alongside the clinical staff is a practice manager who works 20 hours per week. The practice has a dispenser/reception staff member employed for 37.5 hours per week, a dispenser /secretary 20 hours per week, a practice administrator 24 hours per week and part time cleaning staff.

Clinics run by the practice include amongst others; child development, minor surgery, long term condition management which includes a wide range of conditions, for example; diabetes, heart disease and hypertension (high blood pressure) and travel clinics. The Chiropodist provides a clinic on Tuesday afternoons every month by appointment and only after referral by the GP.

The percentage of patients that would recommend the practice to someone new to the area (July 2014 National Patient Survey) is 95% which compares favourably with the practice average across England of 79%.

Practice opening times are from 08.30am to 6pm with the exceptions of Thursday when it opens from 08.30am to 12pm. On Mondays the practice offer an extended service from 08.30am to 7pm. Morning surgeries are run as open surgeries and patients seen in order of arrival and by appointment at reception unless prioritised as an emergency. The practice offers a patient appointment service following the open surgery each day. When the surgery is closed the care and treatment needs of patients are met by the out of hours provider, Shropdoc.

The practice was inspected by the Care Quality Commission in May 2013 under our previous methodology and judged to be compliant.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. 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 data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. The information reviewed did not highlight any areas of risk across the five domain areas. We also spoke with a representative of the Patient Participation Group by telephone and met with three patients.

We carried out an announced visit on 26 November 2014. During our visit we spoke with a range of staff including; the GP, practice manager, nurse, health care assistant, dispensary staff, reception and administration staff. We observed interactions between staff and the patients. We reviewed 44 Care Quality Commission (CQC) comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available to patients prior to inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients. We reviewed a selection of safety records, incident reports and minutes of meetings. The records showed the practice had managed risk effectively and consistently over time and so could show evidence of a safe track record over the long term. The practice manager was aware of their responsibilities to notify the Care Quality Commission about certain events. For example, if there was an occurrence that would seriously reduce the practice's ability to provide care.

Information from NHS England and NHS Shropshire Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety.

Arrangements were in place to identify patients who required annual reviews of on-going care and treatment to ensure it continued to be safe and effective. Care and treatment was provided in an environment that was well maintained.

Learning and improvement from safety incidents

The practice had an effective system in place for reporting, recording and reviewing significant events. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Lessons learned were extracted and shared with staff through team meetings. This helped ensure the practice maintained a regime of continuous improvement.

We found that with any changes to national guidelines, practitioner's guidance and any medicines alerts were discussed at staff meetings and staff also received emailed updates. Staff met on a regular basis and those who attended the meetings confirmed the value and effectiveness of these meetings. This information sharing meant the GPs, nurses and non-clinical staff were confident that the treatment approaches adopted followed best practice. The majority of these meetings were minuted. Minutes which outlined the content of the meetings improve governance mechanisms and minimise the potential of staff misinformation or error.

Reliable safety systems and processes including safeguarding

The practice had policies in place in relation to safeguarding vulnerable adults and children. These were readily accessible to staff on the practice intranet. Staff we spoke with confirmed their awareness of them. The GP acted as a safeguarding lead for the practice. There was a system in place to highlight vulnerable patients on the practice's electronic records.

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies both in working and out of normal hours. Contact details were easily accessible.

The practice advised patients they could have a chaperone present during their consultation if they wished. When a chaperone was requested the role was fulfilled by staff who had been trained in this regard.

Medicines management

We saw that requests for repeat prescriptions were dealt with in a timely way. Arrangements were in place to ensure that changes to patients' medicines for example, following a hospital stay, were reviewed by the GP and uplifted to the practice's electronic record.

Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that prescribed medicines always reflected patients' current clinical needs. All prescriptions were signed by the GP before they were given to the patient. The GP informed us that hand written prescriptions were no longer used at the practice, they were all electronically produced. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

We looked at records to see if medicines requiring refrigeration had been stored appropriately. Records had been completed and showed these medicines had been held within the accepted temperature range, and so were safe to administer.

Good

Are services safe?

The practice operated a dispensing service. Professional support was provided to the dispensary staff by the GP and the community pharmacist. The practice had a system in place to assess the quality of the dispensing process and they had signed up to the Dispensing Services Quality Scheme (DSQS). Standard operating procedures were in place as well as written policies and procedures describing medicines management at the practice.

The dispensary had a controlled drugs register in place (this is for medicines which require extra administration checks to ensure safety) and regular audits of the controlled drugs took place. These were stored appropriately in locked metal cabinets with controlled access by the authorised key holder. The dispensary standard operating procedures included the safe disposal of medicines and appropriate record keeping such as the destruction of any controlled drugs (denaturing).

There were clear cold chain protocols in place. The cold chain is the system of transporting and storing vaccines within the safe temperature range of 2°C- 8°C.

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

The surgery regularly checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. We saw that 100% of patients on repeat medicines had been in receipt of a medicine review in the 12 month period.

The practice showed us their prescribing report dated October 2014 which gave an overview of prescribing in the practice for key therapeutic areas, compared to the CCG and England. The practice was 12% under budget according to the report which provided prescribing specific information.

When making home visits, GPs did not carry paper prescription pads. They used the electronic prescription service as they found this to be safe practice as many patients were on multiple medications. The GP advised us that they took suitable precautions to prevent the loss or theft of their bag on home visits as if medicines were required they were carried in a locked carrying case and would not be left on view in a vehicle.

The GP and staff told us that following a home visit, should a prescription be required, they returned to the practice within the patients records raised an electronic prescription, signed and had it dispensed. When required the GP would then return to the patients home with the medicine.

The door to the dispensary was open rather than closed when staff were in attendance. We discussed with the dispensary manager, practice manager and GP the risks of the door being open should the staff be distracted with patients. The GP informed us that had been discussed during the last CQC inspection visit. They assured us that a risk assessment with clear rationale would be completed and held on record. The door had an appropriate five lever mortice lock in place and metal shutters to the reception area which could only be opened once inside the dispensary.

Cleanliness and infection control

The practice was visibly clean and tidy and the practice employed a cleaner. There were schedules detailing the cleaning tasks to be completed and the frequency with which they should be done. There were records in each room to show when tasks had been completed which evidenced continuity of infection control measures. The practice manager informed us there were no records to show the practice regularly carried out quality assurance checks; however as a small practice they checked each day and were satisfied that appropriate standards were met.

The nurse led on infection prevention and control within the practice, supported by the GP. The practice had an infection control and prevention policy in place which had last been reviewed in April 2014. The policy referred to a number of protocols providing detailed guidance on issues such as hand wash procedures, dealing with spillage involving blood or bodily fluids, and needle-stick injury. Staff showed us the protocols were readily accessible on the practice intranet.

The systems in place for collection and segregation of clinical waste were robust. Supplies of personal protective equipment including disposable gloves and aprons were available to staff to use. Hand hygiene technique signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and paper hand towels were available.

Good

Are services safe?

We looked at the clinical rooms; all the rooms were visibly clean. The nurse and clinical staff were responsible for maintaining infection prevention and control measures within the treatment rooms they worked in throughout the day. There were systems in place to check adequate levels of stock were maintained in all clinical rooms, for example, of personal protective equipment such as disposable gloves.

Equipment

Staff told us they had sufficient equipment to enable them to carry out examinations, assessments and treatments. Records confirmed equipment was tested and maintained regularly. We saw that portable electrical equipment was routinely tested. Stickers were displayed on items indicating the last test date. We saw evidence of the calibration of relevant equipment to ensure it was in working order. Appropriate arrangements were in place with external contractors for maintenance of the equipment and building.

The practice had a defibrillator which ensured they could respond appropriately if a patient experienced a cardiac arrest. Emergency equipment including oxygen was readily available for use in the event of a medical emergency. This equipment was regularly checked by the nursing or dispensary staff.

The business continuity plan was updated regularly with any changes and included contact details in the events of supplier failure and information about their essential equipment suppliers.

Staffing and recruitment

The practice had a stable staff team with the majority of staff employed for at least two years or longer. We looked at three staff recruitment records. The sample included clinical and non-clinical staff. Records contained evidence to demonstrate appropriate recruitment checks had been undertaken prior to employment for the most recent recruits. The records of the most recently recruited staff included relevant checks such as references, as well as criminal record checks by the Disclosure and Barring Service (DBS). The practice manager had systems in place to check clinicians maintained medical indemnity insurance. We noted there was not always proof of identity on staff files. There was not always evidence to show qualifications claimed had been verified. The practice manager explained these checks had been completed but no records maintained. We saw that the practice recruitment policy did not include the completion of DBS checks or proof of identity. They assured us this would be addressed for future recruits.

The practice manager told us that if a locum GP joined the practice on temporary basis they would make checks to ensure their registration with the GMC was valid and check NHS England's performers list. The practice manager informed us that nursing staff copied them into their Nursing and Midwifery Council (NMC) registration updates. We saw that GPs were checked against the NHS performers list and General Medical Council (GMC) and all were registered with license to practice.

Monitoring safety and responding to risk

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were regular reviews in relation to palliative care with updates provided to out of hours providers.

Systems were in place to ensure the number and skill mix of staff available was sufficient to meet patients' needs. Members of staff covered each other's leave. The GP was provided with cover by the salaried GP or they used the same locum GP when required, such as annual leave. They had recently recruited a GP utilising the winter pressures funding for the practice to provide additional GP sessions. There was a workforce contingency plan for annual leave and sickness in place. They demonstrated that their workforce planning was planned in advance where able to minimise the disruption to the service provided to their patients and ensure there was a period of 'handover' between staff.

Reception staff were supported and received training to enable them to carry out a number of duties. Staff took lead roles, for example in infection control and safeguarding adults and children. If any findings identified emerging risks these were fed back to staff so action could be taken to improve service delivery.

The practice manager told us that staff would be notified by email of any actions requiring immediate implementation to ensure they were addressed in a timely manner. Also as a small staff team they spoke with each

other regularly throughout the day. Learning for example from significant events was discussed at scheduled staff meetings to reinforce messages and ensure actions had been completed.

The practice had systems in place to identify, assess and manage risks relating to health and safety. For example fire safety and contingency information was provided to staff within the practice business continuity plan, in the event of emergencies. All staff were aware of the business continuity plan and we saw that this had been regularly reviewed.

We saw evidence that health and safety was managed effectively within the practice. We saw that staff were aware of health and safety issues. For example: needle-stick injury protocols and instruction on the location of equipment for use in emergencies and emergency fire procedures. We saw evidence that the practice had systems in place to ensure fire alarms and equipment were regularly tested and maintained. Emergency exit routes were clearly signposted. All staff completed training on fire safety as part of their induction with further annual reviews. Each consultation and treatment room was fitted with a panic alarm which could be used to raise an audible alert in reception if a member of staff required assistance in an emergency. Alerts could also be raised using their computer systems.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen, a nebuliser and a defibrillator. A nebuliser is a device that converts liquid into aerosol droplets suitable for inhalation. A defibrillator may be used to attempt to restart a person's heart in an emergency. We saw that adult and child pulse oximeters were available for staff to use. These assist staff in monitoring patients' oxygen saturation levels.

Emergency medicines were available in a secure area of the practice and staff knew of their location and appropriate checks of the medicines, such as expiry dates took place. These included those medicines used for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

The consultation, treatment and dispensary rooms were fitted with a panic alarm which could be used to raise an audible alert if a member of staff required assistance in an emergency. Alerts could also be raised using the surgery computer system.

The practice had a business continuity plan in place. It set out how the practice would respond to a range of emergencies that may impact on its daily operation. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to. Staff were up to date with fire training and systems were in place to regularly test the fire alarms and equipment. Fire alarms and extinguishers were placed throughout the building and checks were in date. Fire exits were well signposted and free from any hazards to prevent escape in an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice maintained up to date disease registers for patients with long term conditions such as asthma and chronic heart disease and staff completed annual health reviews. They also provided reviews for patients on long term medication, for example for mental health conditions. We saw that the majority of patients with learning disabilities attended for review within a 12 month period. Patients on the practice mental health register had agreed care plans in place. We discussed what happened when patients did not attend for review. The staff told us that letters were sent to remind patients and where appropriate the GP made contact with them.

The practice held child development clinics and the GP completed the six week checks. The nursing staff team performed the childhood immunisations and vaccination and followed up on patients who did not arrive for their appointments. The practice nurse informed us should teenage pregnancy support be needed they had details for the specialist midwife in order specifically to meet the teenager's needs.

Clinical staff told us how they accessed best practice guidelines to inform their practice and clinical staff met regularly to share such updates as a team and also as peer groups within the local Clinical Commissioning Group (CCG).

Following home visits, for reasons such as vulnerable circumstances or a patients' remote rural location, the GP provided an individual medicine dispensing service where necessary for patients that required it.

The practice employed a healthcare assistant to assist with NHS health checks and phlebotomy (blood taking) investigations to ensure that patients received regular health checks and to assist in the promotion of healthy lifestyles.

We saw that patient referrals, hospital letters, blood results and investigations were monitored and managed effectively to provide a seamless a service as possible between primary and secondary care to their patients.

Management, monitoring and improving outcomes for people

We saw that a variety of clinical audits had been completed and the findings disseminated to all staff. A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. During the audits they considered what worked well, less well, what would have worked better and with improvements what will be different.

A monthly palliative care meeting took place attended by members of the multi-disciplinary team and could include for example; the GP, practice nurse, representatives from nursing homes, and the community nursing teams and MacMillan nurse specialists. The practice recorded the patients palliative care management to ensure every appropriate action had been undertaken, for example informing the out of hours service of palliative care patients.

The practice completed a feverish Illness in children under 5 years old audit. They measured staff compliance with the National Institute of Clinical Health and Excellence (NICE) CG 160 (May 2013) guidance. An audit template tool was devised for staff to use. A repeat audit of a further 50 consultations was carried out to establish whether using this devised tool was effective in ensuring that the correct assessment was carried out and recorded. They concluded the devised tool was helpful and only a small number of occasions when incomplete use of the devised tool had occurred. The practice implemented further in house learning to remind all staff of the potential advantages of using the template.

The practice maintained a summary record of A&E attendances and we saw the report to March 2014. They were aware and reviewed the numbers of patients who had more frequently attended A&E within the 12 month period. Frequent attenders were classed as three or more attendances to A&E. This was in order to identify whether these were avoidable and reduce A&E attendance through patient health promotion and education when appropriate.

Effective staffing

A good skill mix was noted amongst the doctors and nurses with qualifications to allow them to prescribe medicines. The practice had appropriate policies and procedures in place to support staff in carrying out their work. An

induction programme included time to read their policies and procedures. Staff, including locum GPs had easy access to a range of policies and procedures via the computers systems to support them in their work. We were shown the staff induction package which was covered all aspects of the service. Clinical staff had appropriate indemnity insurance coverage in place

We saw that staff training was up to date. The practice manager demonstrated that staff could use their electronic staff training online for certain training topics such as information governance, health and safety and confidentiality. Staff had access to and completed training in the Mental Capacity Act (2005) and "best interests" decisions and could locate appropriate support and guidance.

Clinical staff took responsibility to maintain their appropriate professional refresher training in a timely manner; this included the training expectations in line with national guidance as well as those of the local Clinical Commissioning Group (CCG). A training policy was in place and training included in-house training, external training courses and on-line in the form of E-Learning. The practices mandatory training included for example annual fire safety, and building security. The practice manager maintained a training log for all staff other than the GPs. GPs were up to date with their yearly continuing professional development requirements. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation.

All staff had annual appraisals to review performance at work and identify learning and development needs for the coming year. Although no formalised staff supervision was recorded staff felt they received appropriate support and used their regular meetings as group support. The GP, nurse, reception and dispensing staff told us they enjoyed working at the practice for their patients. All felt their strength was in the fact that they worked as a cohesive team and had good access to support from each other.

There was a range of staff meetings to support staff, as a form of effective communication, provide learning opportunities. These included amongst others: monthly practice nurse meetings, monthly team representative meetings, reception team meetings, patient participation meetings quarterly, monthly palliative care meetings and daily GP referral review meetings.

Working with colleagues and other services

The practice worked with other health and social care providers to meet patients' needs. They worked with the local community nursing team, midwives, health visitors, and for patients with learning disabilities multi-disciplinary teams amongst others. The practice held long term conditions team (LTC) meetings at least every six months and monthly palliative care meetings. . All LTC patients were identified within the patient's record. The LTC meetings ensured the GPs and surgery staff were aware of the patients with current major problems or concerns. The practice said there was excellent communication between the practice and the community team such as district nurses.

Care home patients represented a small percentage of the practice patient list. The GP informed us that their care home patients had at least a yearly medicines review. The GP and practice nurse informed us that contact was made with the out of hours (OOH) provider to make sure there was a full exchange of information about any patients receiving palliative care.

Patients with a learning disability where invited to the practice for annual reviews. These reviews may include investigations, such as blood tests. The nurse and GP informed us that learning disability patients were supported to become fully involved in their care and in making decisions. They told us that patients carers, or support staff, such as residential or care organisation staff, advocates or the patients families, supported patients, when making appointments and attending the surgery.

A member of staff was responsible for ensuring that patients' blood results and investigations, discharge and consultant specialist's letters and referrals were prioritised, seen by the GP and completed in a timely way. We saw that there were systems in place and a staff member responsible for maintaining a spreadsheet to ensure that this took place effectively. We saw that patient referrals, hospital letters, blood results and investigations were monitored and managed effectively to provide a seamless a service as possible to the patients. In the event that the staff member was absent the process enabled other staff to take on this role. Systems were in place to notify a patient's usual GP in a timely manner if a non-registered patient had required treatment.

The practice had been innovative and was involved in a scheme called Compassionate Communities (Co Co). Staff

recruited volunteers and co-ordinated support for individuals the impact of which was to improve people's wellbeing. This is a voluntary organisation that provided support for local people at home, helping them maintain their independence. They provided a befriending service for potentially isolated or unsupported people, which assist them to stay connected socially with friends or with local activities. The service provided companionship that prevented loneliness and access to other local social activities. The practice receptionist/dispenser was a Co-Co-co-ordinator. They had recruited twelve local volunteers who received training. This voluntary service did not include any regulated activities such as personal care.

The practice had an in house community care co-ordinator. The introduction of care co-ordinators based in GP practices was a CCG initiative, designed to provide as much support through community settings as possible to enable patients to live independently for longer.

Information sharing

We saw that the staff completed information governance training which included amongst others; records management and the NHS Code of Practice, access to health records, secure transfers of personal data and password management. Access to patient information was dealt with in accordance with NHS guidelines. The practice followed the Caldicott

Principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent, unless there were exceptional circumstances as stated in the above mentioned Acts.

Staff were able to clearly explain the processes, checks and safeguards that took place for the safe transit of patient's paper and electronic records. Information sharing took place appropriately, such as within multi-disciplinary team meetings, best interest decision meetings, safeguarding adults and children, advanced directives, palliative care meetings and shared care such as hospital referrals and discharges and community team involvements.

Consent to care and treatment

Nursing staff were aware of how to locate the surgery information which dealt with the Mental Capacity Act (MCA) 2005 and understood what was meant by best interest decisions. This legislation is a legal requirement that needs to be followed to ensure decisions made about patients who do not have capacity are made in their best interests. We found the GP was aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their practice.

The nurse or GP sought consent and approval for treatments such as vaccinations from the child's legal guardian. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of the GP's practice and electronically recorded in the patient's record.

Health promotion and prevention

All new patients were asked to complete a health questionnaire and offered a consultation with the nurse or health care assistant. We found that staff proactively gathered information on the types of needs patients had and understood the number and prevalence of different health conditions being managed by the practice.

Patients were encouraged by the practice to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being. We saw the practice had promoted flu vaccination. Patients saw the promotion literature and the practice had put measures in place to ensure that the needs of the patients regarding flu vaccination could be met.

We saw that there was a range of health promotion information on display in the waiting area patients used. On the day of the visit we also saw information such as details about the local patient participation group, social activities locally, Compassionate Communities, Red Cross information and the service it offered all provided on a health promotion boards. The Patient Participation group assisted with ensuring patients had access to the most up to date local information regarding a variety of local support groups and social meetings and initiatives.

The practice told us about a local initiative run by Age UK called Walking Football which was a new version of the game, especially for older people, on Thursday mornings. It had the same rules as a five aside game but with one main

Are services effective?

(for example, treatment is effective)

difference, no running. The practice encouraged and referred patients who would most benefit from this to attend and engage with this initiative to promote a more active lifestyle for their health and wellbeing.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients spoke positively of their dealings with both clinical and non-clinical staff. We spoke with three patients on the day of our inspection they told us they were treated with dignity and respect; they said that practice and dispensary offered an excellent service and staff were kind, thoughtful and caring. Without exception the 44 CQC comment cards received and the patients we spoke with commented positively on the practice and the kindness of the staff. All were extremely complimentary about the care and treatment being provided. They found the GPs and nurse delivered a personalised service and had an excellent understanding of their needs. NHS England's GP Patient Survey July 2014 found that 95% of respondents would recommend this practice to someone new to the area.

We saw staff speaking with patients attending the practice and heard them engaged in conversation with patients on the telephone. They followed the practice confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We saw that staff were friendly, polite and respectful in dealing with patients. The reception staff dealt with incoming calls and made outgoing calls as far away as possible from the reception front desk area. Therefore when patients contacted the practice they could be assured that their call was not inappropriately overheard. When patients approached the front desk reception area they could request to speak with the staff in a private room.

We saw that doors were closed during patients' appointments. Notices were displayed in the reception area advising patients they could have a chaperone present during their consultation if they so wished. Clinical staff were trained to act as chaperones.

Care planning and involvement in decisions about care and treatment

Patients confirmed that they felt involved in decisions about their care and treatment. They told us diagnosis and treatment options were clearly explained. They told us they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do and returning. They also told us they felt listened to and supported by staff and had sufficient time during consultations. The GP informed us that care plans were in place for vulnerable patients.

Patients confirmed they were able to contact the practice and speak with staff in a timely and accessible manner. One patient told us they found they always received quick responses when concerns related to their child.

Patient/carer support to cope emotionally with care and treatment

Multi-disciplinary palliative care meetings were held on a monthly basis to discuss the needs of those approaching the end of their life. Systems were in place to appropriately prioritise support required. Patient preferences such as advanced directives were shared only with appropriate healthcare partners to ensure they were met, for example, out of hour's services.

Patients described the confidence and trust they had in the practice and that they had been treated with sensitivity and staff were empathetic. The practice provided patients and carers with information on their notice boards about where and when the next carers meetings would be held.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice conducted its own patient survey with results published in September 2013. All patients that attended during a 10 day working period in September 2013 were asked to complete a satisfaction questionnaire. In total 100 questionnaires were given to patients to complete during the study period following their consultation at the surgery. All were completed and returned, a 100% response rate. Overall the results indicated that patients felt the practice offered a very good service. Patients felt that the service was exceptionally good and that their views were listened to and valued by the staff.

Patients were aware of the weekday open walk in surgery and all the patients we spoke with confirmed they would be offered a same day appointment. Some patients said they occasionally had to wait to see the GP but told us they preferred to do so and be assured they could be seen by the GP that same day.

We saw that interpreter services could be arranged for appointments, staff spoken with were aware of the service but it had yet to be required. Literature was available signposting patients to healthy activity programmes, therapeutic groups, carers meetings and flu vaccinations.

The practice had an active patient participation group (PPG) who met every four months and minutes were taken of these meetings. We spoke to a member of the PPG who raised no concerns. The practice informed us that there was a planned event in February when young people would present to the group their research and finding regarding supporting people such as family members with a dementia diagnosis. The PPG endeavoured to encourage patient participation where possible across the whole spectrum of patients registered at the practice.

Tackling inequity and promoting equality

Staff had awareness of equality and diversity. The new patient list was open and staff were able to offer appointments to patients, for example patients with no fixed abode. This was designed to tackle current health inequalities, promote equality and fairness and establish a culture of inclusiveness.

The nurse held a number of regular clinics at the surgery to review for example chronic disease management, immunisation and vaccination smoking cessation and diabetes to provide health promotion information and advice. The healthcare assistant also provided NHS checks for patients. The practice had access to online and telephone translation services.

Access to the service

The practice was visibly clean and well maintained. There was an accessible car park. There was ground level entry to the building. All consultation and treatment rooms were on the ground floor. A disabled toilet and baby change facility was available. Staff informed us that patients who were wheelchair users could access the service but did have to negotiate the doors with staff help when required, as the doorways were not electronically operated. The reception area was spacious and well furnished with ample seating. Practice opening times were from 8.30am to 6pm, with the exception of Mondays 08.30am-7pm extended service, and on Thursdays the practice operated from 08.30am to 12pm. When the practice was closed patients were signposted to the out of hours service.

We discussed with the practice how they met the needs of the working age population as the largest percentage of the surgery population, 58.4%, were of working status either paid work or in full-time education. Staff told us the practice had same day appointments available and were able to meet patient's needs. The National Patient Survey July 2014, findings were that 65% of patients who responded usually waited 15 minutes or less after their appointment time to be seen, which was in line with the CCG (regional) average 66%. None of the patients spoken with or the 44 CQC comment cards received suggested that obtaining urgent appointments had been problematic as the practice held an open surgery every day, and in general patients told us they preferred to wait and be seen and the same day. We found that home visits and same day appointments were available every day. Practice opening times were detailed in the surgery leaflet which was available in the waiting room for patients and website.

Listening and learning from concerns and 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 surgery. The manager showed us the complaints and compliments summary from October 2013 to November 2014 of which there were

Good

Are services responsive to people's needs?

(for example, to feedback?)

eight recorded, both clinical and non-clinical. Of these five were compliments and three were complaints, two formal and one informal. All were resolved and we saw that each complaint was fully investigated and actioned where appropriate to do so.

We saw that information was available to help patients understand the complaints system and information on how to make a complaint was within the surgery information leaflet.

Patients we spoke with said should they wish to make a complaint they would read the information leaflet or approach the reception staff for advice and further information. None of the patients spoken with had needed to make a complaint about the surgery.

Are services well-led?

Good

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

Our findings

Vision and strategy

Staff told us about the various meetings they attended to help keep them up to date with any new developments, professional updates and of any medical devices alerts or concerns. Staff knew what their responsibilities were and told us they wanted to continue to provide a good service for patients and were enthusiastic about their contribution.

We saw evidence that showed the practice worked with the CCG to share information, monitor performance and implement new methods of working to meet the needs of local people where appropriate to do so.

The GP attended various meetings and shared information amongst others and appropriately shared information with their staff team. Staff were aware and engaged with multi-disciplinary team working. There was a very clear strategic vision in respect of staff roles, responsibilities, staff succession planning, career progression, education and training.

Governance arrangements

The GP had lead roles and took responsibility for a number of clinical areas and responsible for decisions in relation to the provision, safety and quality of care and worked with the practice manager to ensure identified risks were acted upon. Individual aspects of governance such as complaints, risk management and audits within the surgery were allocated to appropriate staff.

The practice submitted governance and performance data to the CCG. The GP had completed a number of clinical audits, acted on findings and implemented changes where indicated.

Leadership, openness and transparency

The practice had systems to identify, assess and manage risks related to the service. We saw there was clear guidance available for staff in a number of the policies we reviewed. There was evidence of staff involvement in the various minutes of the meetings staff attended and that relevant information was cascaded to all staff groups. 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. They were aware of the whistleblowing policy and told us they knew who they could go to for support.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example; disciplinary procedures, induction policy and, safeguarding policy which were in place to support staff. Staff we spoke with knew where to find these policies if required. Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed with staff and if necessary changes were made to procedures and staff training put in place.

We saw that audits and checks took place to monitor the quality of services provided and that the findings were acted upon.

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

We saw from minutes of meetings that staff members attended role appropriate meetings and contributed to the running of the practice. Staff told us they were encouraged to make suggestions and contribute to improving the way the services were delivered. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The 44 CQC comment cards received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained. The patient participation group (PPG) gathered information in response to patient's comments to enable the surgery to listen, act and respond appropriately. The PPG informed us that the practice was responsive, engaged and was proactively involved with the PPG. The PPG had carried out regular patient surveys. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

Management lead through learning and improvement

There was a clear focus on clinical excellence and a desire to achieve the best possible outcomes for patients. The practice operated an 'open culture' and actively sought feedback and engagement from staff, patients and the CCG all aimed at maintaining and improving the service.

The practice had completed reviews of significant events and other incidents and shared these with staff via

Are services well-led?

Good

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

meetings to ensure the practice improved outcomes for patients. Staff told us about how they learned from significant events and the improvements and reviews following any change implementation that took place.

The GPs and managers were very supportive of staff's personal development and provided staff with extra support to achieve qualifications which would increase the staff member's effectiveness and that of the service provided to their patients.