Dr Stephen Hilton

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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive announced inspection at Dr Stephen Hilton (also known as Elvaston Road Surgery) on 15 January 2015. Overall, the practice is rated as requires improvement. Specifically, we found the practice to be requires improvement for providing safe and well led services, with the practice rated as good at providing effective, responsive and caring services. However, there were aspects of the practice which required improvement which related to all population groups.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses;
- The practice was clean and hygienic;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Nationally reported patient outcomes were mostly either in line with, or better than average, when compared to the local Clinical Commissioning Group (CCG) and England averages;
- Patients said they were treated with dignity and respect and they were involved in decisions about their care and treatment. Patients told us the practice met their needs;
- Information was available about the services provided by the practice and it was easy to understand, as was information about how to raise a complaint;
- Patients said they found it easy to make an appointment and urgent, same-day access was available;
- The practice was equipped to treat patients and meet their needs;
- Staff were committed to delivering good care to their patients. The team worked well together and supported each other.

However, there were areas of practice where the provider needs to make improvements. Importantly the provider must:

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- Take action to make sure there are safe and proper arrangements in place for the management of medicines. In particular, the practice must: review the systems and processes for the safe handling of prescriptions; ensure effective processes are in place to monitor vaccine expiry dates and maintain a 'cold-chain' when transporting vaccines;
- Take action to make sure there are safe and proper arrangements in place for assessing the risk of, and controlling and preventing the spread of infections.

In addition, the provider should:

- Carry out regular reviews of the practice's Legionella risk assessment;
- Carry out a risk assessment to determine which emergency drugs, including oxygen, are required by the practice;
- Provide a business continuity plan which can be accessed by all staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

The nationally reported data we looked at contained no evidence of risk relating to the provision of safe services. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners and the practice team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. There were enough staff to keep patients safe and meet their needs. The practice was clean and hygienic. However, there was no recorded evidence demonstrating the practice had taken appropriate action to comply with relevant infection control guidance. This could place patients at risk of receiving inappropriate care and treatment. Most aspects of medicines management were safe, but we found the arrangements for monitoring vaccine expiry dates, transporting vaccines, and the safe handling of prescriptions, were not effective and patients could potentially receive ineffective vaccinations.

Are services effective?

Good

The practice is rated as good for providing effective services.

The nationally reported data we looked at contained no evidence of risk relating to the provision of effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). Staff had received training appropriate to their roles and responsibilities. Arrangements had been made to support clinical staff with their continuing professional development. There were effective systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

The nationally reported data we looked at contained no evidence of risk relating to the provision of caring services. Patient responses to

Summary of findings

the National GP Patient Survey, published in January 2015, were mostly above the national average, and for some responses they were also above the local Clinical Commissioning Group (CCG) average.

Most patients were satisfied with the care and treatment they received and said they were involved in making decisions about their care and treatment. Arrangements had been made to ensure patients' privacy and dignity was respected. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. Staff understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The nationally reported data we looked at contained no evidence of risk relating to the provision of responsive services. Patient responses to the National GP Patient Survey, published in January 2015, were above both the local CCG and national averages for both indicators.

Services had been planned so they met the needs of the key population groups served by the practice. Patient feedback about the practice was good. The practice had taken steps to reduce emergency admissions to hospitals for patients with complex healthcare conditions, and older patients had been allocated a named GP to help promote continuity of care. The practice had satisfactory facilities and was equipped to treat patients and meet their needs. There was an accessible complaints procedure which was easy to understand.

Are services well-led?

Requires improvement

The practice is rated as good for providing well led services.

The nationally reported data we looked at contained no evidence of risk relating to the provision of well led services.

The practice had a clear vision for maintaining the services they provided and the leadership team was committed to promoting good patient outcomes. Staff were clear about their roles and understood what they were accountable for. The practice actively sought feedback from patients and had made arrangements to further improve how they obtained feedback through the development of a patient participation group (PPG). Effective arrangements had been made to obtain feedback from staff about the day-to-day running of the practice. However, the arrangements in place for governance did not always operate effectively. Whilst we

Summary of findings

found evidence that some aspects were good, we identified a number of areas where improvements were needed. For example, the practice had not identified and addressed shortfalls in the system for monitoring vaccine expiry dates, the arrangements for transporting vaccines and the safe handling of prescriptions. Also, the practice had not made sure there were proper arrangements in place for assessing the risk of, and controlling and preventing the spread of infections.

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

Requires improvement

The practice is rated as requires improvement for the care of older patients. There were aspects of the practice which required improvement and related to all population groups.

Nationally reported QOF data (2013/14) showed patient outcomes relating to the conditions commonly associated with this population group were mostly above the local CCG and England averages. For example, QOF data showed the practice had achieved 100% of the total points available to them for providing patients with heart failure with the recommended care and treatment. This was 0.9 percentage points above the local CCG average and 2.9 points above the England average.

The practice provided proactive, personalised care to meet the needs of older people. They provided a range of enhanced services including, for example, allocating a named GP who was responsible for overseeing the care and treatment provided to older patients. Clinical staff had received the training they needed to provide good outcomes for older patients. The practice was responsive to the needs of older people, and offered home visits and access to urgent appointments for those who needed them.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of patients with long-term conditions. There were aspects of the practice which required improvement and related to all population groups.

Nationally reported QOF data (2013/14) showed patient outcomes relating to the conditions commonly associated with this population group were mostly above the local CCG and England averages. QOF data showed the practice had achieved 96.9% of the total points available to them for providing patients with diabetes with the recommended care and treatment. This was 4.1 percentage points above the local CCG average and 6.8 points above the England average.

The practice had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. All the patients on the practice's long-term conditions registers received healthcare reviews that reflected the

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severity and complexity of their needs. Person-centred care plans had been completed for patients with long-term conditions. Clinical staff had received the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. There were aspects of the practice which required improvement and related to all population groups.

Nationally reported data (2013/14) showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These were both above the England averages (i.e. 0.9 and 1.2 percentage points above respectively) and were in line with the local CCG averages.

Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. Where comparisons allowed, we were able to see that the delivery of childhood immunisations was mostly higher when compared with the overall percentages of children receiving the same immunisations within the local CCG area. For example, MMR vaccination rates for five year old children were 94.9 % compared to an average of 91.5% in the local CCG area. All five childhood immunisations delivered to babies aged 24 months were above each local CCG average. Regular baby clinics were held by the practice nurse, and ante-natal classes were offered by an attached healthcare professional. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age patients (including those recently retired and students.) There were aspects of the practice which required improvement and related to all population groups.

Nationally reported QOF data (2013/14) showed patient outcomes relating to the conditions commonly associated with this population group were mostly above the local CCG and England averages. For example, the data showed the practice had achieved 100% of the total points available to them for providing care and treatment for patients with cardiovascular disease. This was 10 percentage points above the local CCG average and 12 points above the England average.

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The needs of this group of patients had been identified and steps had been taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients. Patients could order repeat prescriptions and book appointments on-line. Extended hours appointments were available until 7:00pm one evening a week. Health promotion information was available in the waiting area and on the practice web site. The practice provided additional services such as smoking cessation and weight management.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of patients whose circumstances may make them vulnerable. There were aspects of the practice which required improvement and related to all population groups.

Nationally reported data (2013/14) showed the practice had achieved 100% of the total points available to them for providing care and treatment for patients with epilepsy. This was 14.3 percentage points above the local CCG average and 10.6 points above the England average.

Staff worked with relevant community healthcare professionals to meet the needs of vulnerable patients registered with the practice. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, recording safeguarding concerns and contacting relevant agencies.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of patients experiencing poor mental health (including people with dementia). There were aspects of the practice which required improvement and related to all population groups.

Nationally reported QOF data (2013/14) showed patient outcomes relating to the conditions commonly associated with this population group were mostly above the local CCG and England averages. For example, the data showed the practice had achieved 100% of the total points available to them for providing care and treatment for patients with mental health needs. This was 6 percentage points above the local CCG average and 9 points above the England average.

The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests.

Summary of findings

Patients were able to access specialist counselling and support at the practice. Where appropriate, care plans had been completed for patients who were on the register. Practice staff worked with other community healthcare professionals to help ensure patients' needs were identified and met. However, outcomes for patients with dementia were below both the local CCG and England averages.

Summary of findings

What people who use the service say

During the inspection we spoke with one patient and reviewed 30 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated all the patients were satisfied with the care and treatment they received. Patients told us they received a good service which met their needs.

Of those patients who responded to the National GP Patient Survey, published in January 2015:

- 88% said the last GP they saw, or spoke to, was good at listening to them (in line with both the local Clinical Commissioning Group (CCG) and national averages);
- 85% said the last GP they saw or spoke to was good at giving them enough time (just below the local CCG average (86%) and the national average (86));
- 83% said the last GP they saw or spoke to was good at treating them with care and concern (just below the local CCG average (84%) but above the national average (82%));
- 83% said the last GP they saw or spoke to was good at explaining tests and treatments (just below the local CCG average (84%) but above the national average (82%));
- 95% said they had confidence and trust in the last GP they saw or spoke to (above both the local CCG (94%) and national averages (93%)).

These results were based on 123 surveys that were returned, out of a total of 261 sent out. The response rate was 47%.

Areas for improvement

Action the service MUST take to improve

The provider must:

- Take action to make sure there are safe and proper arrangements in place for the management of medicines. In particular, the practice must: review the systems and processes for the safe handling of prescriptions; ensure effective processes are in place to monitor vaccine expiry dates and maintain a 'cold-chain' when transporting vaccines;
- Take action to make sure there are safe and proper arrangements in place for assessing the risk of, and controlling and preventing the spread of infections.

Action the service SHOULD take to improve

In addition, the provider should:

- Carry out a regular review of the practice's Legionella risk assessment;
- Carry out a risk assessment to determine which emergency drugs are not required by the practice;
- Provide a business continuity plan which can be accessed by all staff.

Dr Stephen Hilton

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and a GP.

Background to Dr Stephen Hilton

Dr Stephen Hilton, also known as Elvaston Road Surgery, provides care and treatment to 2309 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of NHS Gateshead Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the Clara Vale, Crawcrook and Ryton areas. It serves an area that has lower levels of deprivation for children and people in the over 65 age group, than the local CCG averages.

The practice provides services from the following address, which we visited during this inspection:

Dr Stephen Hilton, 7 Elvaston Road, Ryton, Tyne and Wear. NE40 3NT.

The practice occupies an adapted private dwelling. The lower ground floor of the premises is fully accessible to patients with mobility needs. The practice provides a range of services and clinic appointments including services for patients with asthma, diabetes and heart disease. The practice team consists of two GPs (one male and one female), a practice manager, a practice nurse, and reception and administrative staff. A member of the reception and administrative team also acts as a healthcare assistant.

When the practice is closed patients can access out-of-hours care via Gateshead Community Based Care Limited, also known as GatDoc, and the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our 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; look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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:

Detailed findings

- 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 held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 15 January 2015. During this we spoke with a range of staff including: the GP provider; the practice manager; a member of staff providing administrative support; the healthcare assistant and members of the reception team. We spoke with one patient who visited the practice on the day of our inspection. One other patient declined to speak with us. The practice was closed on the afternoon of our inspection. We observed how staff communicated with patients who visited, or telephoned the practice, on the day of our inspection. We looked at records the practice maintained in relation to the provision of services. We also reviewed 30 Care Quality Commission (CQC) comment cards that had been completed by patients using the practice.

Requires improvement

Are services safe?

Our findings

Safe Track Record

When we first registered this practice, in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to safety. The Care Quality Commission (CQC) had not received any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Neither the patients who completed CQC comment cards, or the patient we spoke with during the inspection, raised concerns about safety at the practice.

We saw that records were kept of significant events and incidents. We reviewed all of the records completed by practice staff during the previous 12 months. These showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was also evidence that appropriate learning from incidents had taken place and that the findings were discussed with all staff. All of the staff we spoke with were aware of the system in place for raising issues and concerns.

Ten significant events/incidents had been recorded as having taken place during the previous 12 months. The records we looked at included details about what the practice had learned from these events, as well as information about any actions that had been taken to prevent their reoccurrence. For example, a report had been completed regarding an incident where a pharmacy had requested a prescription for a patient. The report showed practice staff had identified the patient concerned had not been prescribed the requested medicine, and immediately contacted the pharmacy to make them aware of this. The event had been discussed during a daily lunch-time meeting that all staff on duty participated in to ensure any practice learning could take place. However, the practice manager told us minutes of the lunch-time meetings where significant events and incidents were discussed were not kept. We asked the practice manager to consider keeping minutes of these meetings.

Arrangements had been made which ensured national patient safety alerts were disseminated to the relevant staff within the practice. This enabled these staff to decide what action should be taken to ensure continuing patient safety, and to mitigate any risks. The practice also reported relevant incidents to the local CCG involving their patients using the local safeguarding incident reporting system. This required them to grade the degree of risk using a traffic light system, and score the potential impact of the incident on patients using their service.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. For example, one of the GPs held lead responsibilities for safeguarding adults and children. Having a safeguarding lead GP helps to promote good professional practice. The staff we spoke to knew which GP acted as the safeguarding lead.

We spoke to the GP responsible for overseeing safeguarding within the practice. They told us they had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. The practice nurse and healthcare assistant had also completed child protection training relevant to their role. The practice manager told us staff had completed adult safeguarding training during 'Time-in Time-out' sessions run by the local CCG. This was confirmed by the healthcare assistant we spoke with. These sessions provide opportunities for staff to learn outside of the practice.

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable

adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability. (Clinicians use READ codes to record patient findings and any procedures carried out). Systems were in place which ensured any incoming safeguarding information was added to patients' medical records.

The practice manager told us the practice did not have written child protection and adult safeguarding policies. Having suitable written policies and procedures helps to ensure staff know what action to take to safeguard children and vulnerable adults, and that this is consistent with best practice. However, we did confirm that clinical staff had access to guidance produced by the local authority.

A chaperone policy was in place. However, information about this was not displayed in the reception area or in the clinical rooms. We told the practice manager about this and they immediately took steps to display notices informing patients of the availability of this service. The patient we spoke with said they knew they could access a chaperone if they needed one. This person confirmed they would trust staff to provide this service and would feel comfortable using it. None of the patients who completed CQC comment cards raised any concerns about having access to a chaperone.

The GP we spoke with told us the practice nurse and healthcare assistant mainly carried out chaperone duties, although occasionally a member of the reception team might be asked to carry out this role. The practice manager said the clinical staff carrying out this role had completed training provided by the local CCG. However, a member of the clinical team who might have to undertake chaperone duties had not undergone a Disclosure and Barring Service (DBS) check. (These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There was no recorded risk assessment in place regarding the use of this member of staff to carry out chaperone duties without a DBS check.

Medicines Management

Blank prescriptions were stored securely but the recording and audit trail did not comply with the national guidance, i.e. 'NHS Protect: Security of Prescription Forms.' We found a system was not in place to ensure a record was kept of blank prescription form serial numbers on receipt into the practice and when the forms were issued to the GPs.

The arrangements for monitoring the expiry dates of vaccines held at the practice were not effective. The practice manager told us there was a system in place for monitoring vaccine expiry dates. However, a small number of the items stored in one of the refrigerators had exceeded their expiry date by several months. The potential use of out-of-date vaccines places patients at risk because they may not receive an effective treatment. The practice manager told us staff always checked expiry dates prior to the administration so this would minimise the potential risk to patients.

The arrangements for maintaining the 'cold-chain' for influenza vaccines transported a short distance from the practice to a local church were not effective. (A cold chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature). Practice staff told us they transported the vaccines using a cool box. However, this was not a medical grade cool box and a thermometer was not used to check temperatures before and after transportation. Although these journeys were short, failure to maintain an unbroken 'cold chain' potentially placed patients at risk of receiving ineffective vaccines.

Arrangements were in place to manage repeat prescribing safely. Patients were able to order repeat prescriptions in a variety of ways. This included visiting the practice, or ordering by telephone, on-line and by post. The practice web site provided patients with helpful advice about ordering repeat prescriptions.

Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. The staff involved with this process were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. A member of the reception team told us all repeat prescription requests were sent through to the GP partners for checking and authorisation.

Arrangements had been made which ensured that all emergency medicines were safe to use. A designated

member of staff was responsible for monitoring the expiry dates of emergency medicines and the ordering of new supplies. We found all emergency medicines were within their expiry date.

Cleanliness & Infection Control

The systems for monitoring whether patients were fully protected from the risk of infection required improvement. There was no evidence the practice had carried out their own risk assessment to help them decide which parts of the Health and Social Care Act (HSCA) 2008 Code of Practice on the Prevention and Control of Infections applied to them. Also, an infection control audit had not been carried out at the time of our visit. Failing to carry out regular infection control audits may mean that the practice has no evidence that their staff are following the Code of Practice or any local best practice guidelines.

The practice manager told us the practice did not have a written policy regarding the control of legionella. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.) Providing a Legionella policy will help ensure that all staff are clear about the steps taken by the practice to minimise potential risks to patients' wellbeing. The practice had arranged for an external body to carry out a comprehensive legionella risk in 2010. However, the practice manager told us that this had not been reviewed since its completion. Carrying out a regular review of this risk assessment will help ensure it remains relevant and up-to-date.

The practice had an infection control policy. The policy identified who the practice leads were and what they were responsible for. A comprehensive and up-to-date needle stick and blood-borne viruses policy was in place and provided staff with guidance about how they were expected to respond should they suffer exposure or an injury. The reception team told us how they would clean up a spill of bodily fluid and this was in line with the guidance contained within the policy. However, spillage kits were not available for use within the practice. These kits enable practice staff to clear blood or body fluid spillages safely without exposing themselves to infectious organisms. We told the practice manager about this and they immediately took steps to purchase a suitable kit. Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, the practice had a clinical waste contract for its safe disposal. All waste bins were visibly clean and in good working order. The healthcare assistant we spoke with was clear about which waste bin should be used for each type of waste.

The premises were clean and hygienic throughout. Notices reminding patients and staff of the importance of hand washing were on display in toilets and other areas of the practice. The patient we spoke to told us the practice was always clean. Cleaning was undertaken by a member of the administrative team. They were clear about what cleaning was required and to what standard. They told us they had access to all of the equipment and materials they needed to keep the practice clean.

Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. However, the bin in one consultation room had not been dated or initialled by the member of staff who had assembled it. Consultation rooms contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be laundered/changed on a regular basis.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The healthcare assistant we spoke with confirmed this. The equipment was regularly inspected and serviced. We saw records confirming the calibration of practice equipment had taken place during the last 12 months. Arrangements had also been made to ensure that other equipment was safe and fit to use. For example, the practice's fire extinguishers had recently been checked and inspected by an external contractor. The boilers were regularly serviced. An up-to-date certificate was in place confirming the safety of the electrical systems within the practice.

Staffing & Recruitment

The practice had a set of recruitment policies and procedures which provided clear and detailed guidance about how staff would be recruited and what checks would be carried out. However, the policy had not been reviewed

since 2010, and contained information that was out-of-date. For example, the recruitment policy included references to the Independent Safeguarding Authority which no longer operates.

The practice manager told us staff turnover was low and some staff had been employed at the practice for a significant number of years. Pre-employment checks had been undertaken to help make sure only suitable staff were employed. Clinical staff had NHS Smart cards containing an identification photograph. Staff only receive this card after their identity has been verified under the NHS Employment Check Standards process.

The GP partners had undergone a Disclosure and Barring Service (DBS) check as part of their application to be included on the National Medical Performers' List. (All performers are required to register for the online DBS update service which enables NHS England to can carry out status checks on their certificate.) A DBS check had been carried out for the member of staff who was employed both as a healthcare assistant and as a member of the reception team. However, a DBS check had not been carried out for a member of the clinical team. The practice manager told us this was because the member of staff had been appointed in 1998 before the practice was registered. It was clear that the practice manager had not intended to disregard the relevant regulation or the practice's own recruitment policy. Instead, they had considered that, in this instance, these did not apply. The practice manager told us they would ensure that an appropriate DBS check was carried out.

We checked both the General Medical and Nursing and Midwifery Councils records and confirmed all of the clinical staff working at the surgery were licensed to practice. The practice manager told us they carried out checks to make sure there were no lapses in staff's professional registration.

Monitoring Safety & Responding to Risk

The practice manager monitored the safety of the building to ensure patients and staff were not placed at risk. This included carrying out regular checks of the premises to make sure there were no hazards. We checked the building and found it to be safe and hazard free. No concerns were raised in the CQC comment cards completed by patients.

However, an assessment of risks relating to the operation of the premises and the carrying out of everyday activities had not been carried out. Also, some risk assessments had not been regularly reviewed.

More effective systems were in place for managing and monitoring risks to patients. For example, the practice had used a risk assessment screening tool to identify those patients at risk of an unplanned admission into hospital. Care plans were in place for high risk patients, and the practice had provided professionals with access to an emergency number should they need to contact the practice urgently to discuss a patient's condition.

The practice completed significant event reports where concerns about patients' safety and well-being had been identified. Arrangements were in place to learn from patient safety incidents and promote learning within the team.

Arrangements to deal with emergencies and major incidents

A recorded business continuity plan for dealing with potential emergencies that could impact on the daily operation of the practice had not been prepared. The practice manager told us consideration had been given to how the practice would operate in an emergency. We were told arrangements had been made with a local practice to assist them in the event of an emergency. Maintaining a written business continuity plan helps to provide staff with clear accessible guidance about the action they should take in the event of an emergency.

The practice had put arrangements in place to manage emergencies. Emergency medicines were available. These included, for example, medicines for the treatment of a life-threatening allergic reaction. However, emergency oxygen was not available. A recorded risk assessment had not been completed regarding the decision made by the practice not to keep emergency oxygen. Staff had received training in cardio-pulmonary resuscitation (CPR) and there was equipment available for use in emergencies. This included an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and an emergency medicines kit. The staff we spoke with knew the location of this equipment. The practice manager told us the practice nurse carried out checks to make sure this equipment was in good working order and fit for purpose.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP we spoke with was able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance, and were able to access National Institute for Health and Care Excellence (NICE) guidelines via the practice IT system. They attended a regular post-graduate education meeting for GPs which provided opportunities for continuous professional learning. From our discussions with the GP we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines. Patients' needs were reviewed as and when appropriate. The practice made use of care plan templates to guide and record the outcomes of their consultations with patients, especially those with long-term conditions.

Clinical responsibilities were shared between both the GPs and the practice nurse, to help ensure each member of staff was clear about their roles and responsibilities. The clinical and non-clinical staff we spoke with were very open about asking for and providing colleagues with, advice and support. For example, the healthcare assistant told us they understood their role as a healthcare assistant and received support from the wider team to develop their skills and competencies.

Nationally reported data, taken from the Quality Outcomes Framework (QOF) for 2013/14, showed the practice had overall achieved 98.3% of the total achievement points available to them for providing recommended treatment to patients with the commonly found health conditions covered by the scheme. This was 3 percentage points above the local Clinical Commissioning Group (CCG) and 4.8 points above the England averages. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions, such as diabetes, and implementing preventative measures. The results are published annually.)

Practice staff had the knowledge, skills and competence to respond to patients' needs. The GP we spoke with had recently completed their first five yearly re-validation cycle which meant they would have satisfied their NHS Responsible Officer that they had continued to develop through continuing training and refresher education relevant to their clinical role. The practice nurse had updated their training on, for example, carrying out cervical smears and immunisations. The healthcare assistant we spoke with confirmed they had all of the training they currently needed to carry out their role. Practice staff had also completed cardio pulmonary resuscitation (CPR) training.

Interviews with the GP and healthcare assistant demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients' age, sex and race was not taken into account in this decision-making. The patient we spoke with said they felt well supported by the practice GPs and were involved in making decisions and choices about their treatment. This was also reflected in the comments made by patients who completed Care Quality Commission (CQC) comment cards.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, the GP we spoke with had a special interest in substance misuse, and provided a service to both registered and non-registered patients who needed support with drug addiction management. The other GP had completed a family planning diploma and had an interest in women's health. Other staff had been given responsibilities for carrying out designated roles including, for example, the ordering and monitoring of emergency drugs.

The GP we spoke with had recently achieved re-validation. This would have required that they complete at least one full clinical audit cycle as part of demonstrating the quality improvement activity they had undertaken during the previous five years. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice staff had carried out audits in relation to the enhanced services they provided, as well as to check their progress in delivering recommended care and treatment for the clinical conditions covered by the QOF and against CCG prescribing targets. We were shown data from a Shared Care substance misuse drug audit. From the results

Good

Are services effective?

(for example, treatment is effective)

we were able to see that the practice had offered patients appropriate checks such as testing for blood-borne viruses and providing opportunities for them to receive appropriate vaccinations. However, the audit had not been presented in the style and format recommended by the Royal College of General Practitioners. We also saw no evidence of clinical audit activity generated by significant events and incidents occurring within the practice.

The practice had also carried out a number of audits in response to the medicines alerts they had received. For example, they had written to all patients prescribed an Adrenaline injector pen to make sure they had access to the latest advice. Numerous other medicines related audits had been carried out by the practice and their prescribing advisor. For example, the prescribing adviser had carried out an audit to ensure any patient prescribed an unlicensed medicine had received a GP review, and was receiving the most cost effective drug preparation. A review had also been carried out to check whether there were any patients with dementia receiving an antipsychotic medicine, and to ensure this was only happening after the relevant prescribing guidance had been followed. The practice manager told us any patient follow-up that was needed was referred to the GPs for action.

The practice was proactive in the management, monitoring and improving of outcomes for patients. The practice used the information they collected for the QOF, and information about their performance against national screening programmes, to monitor outcomes for patients. For example, 100% of the eligible patients with cancer, diagnosed within the previous 15 months, had had a review recorded within three months of the practice receiving confirmation of their test results (this was 9.8 percentage points above the local CCG average); 92.9% of patients with a diagnosis of heart failure had had this confirmed by an echocardiogram (ECG), or by a specialist assessment, three months before, or 12 months after, being entered onto the practice's disease register (this was 2.8 percentage points below the local CCG average.) (An ECG is equipment used to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain.) The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF clinical targets.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The GP we spoke with had a special interest in substance misuse and providing services to patients with a drug addiction. They told us they had completed additional training to enable them to provide this service and that their competency in this area was reviewed during their yearly appraisal. The GP also worked for the local out-of-hours service to help maintain their skills and competencies. The salaried GP had a special interest in women's health and had completed a diploma in family planning.

We were unable to speak to the practice nurse as they were not available on the day of our inspection. However, we were able to speak to the healthcare assistant who told us they were only expected to perform defined duties for which they had received appropriate training. Our interviews with staff confirmed the practice was proactive in providing staff with access to appropriate training that was relevant to their role.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. Arrangements were in place to ensure that effective staff cover was maintained at all times. This helped to ensure the team was able to maintain services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communications from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice held regular multi-disciplinary meetings to discuss patients with complex needs, for example, those with end of life care needs. These meetings were attended by the GPs and practice nurse as well as other local healthcare professionals such as health visitors. Minutes were kept of each meeting.

Information Sharing

Good

Are services effective?

(for example, treatment is effective)

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. We saw paper patient records were kept behind the reception desk. The practice manager told us they had assessed the risks this posed. They said as no confidential information could be seen by patients, and access to this area was limited to staff, they had judged the risks to be minimal given the safeguards that were in place. Administrative staff identified which paper medical records would be needed for the following day and made sure these were available to assist with the smooth running of the surgeries. Systems were in place which ensured that patient referrals were handled efficiently. The staff we spoke with were clear about their role and responsibilities for handling patient referrals. Staff told us these systems worked well.

The practice used several systems to communicate with other providers. For example, there was an agreed process for sharing information with, and receiving information from, the local out-of-hours provider. We were told the practice received faxes from the out-of-hours provider regarding any contacts they had had with their patients, which were reviewed by the GPs. The staff we spoke with were clear about how other information coming into the practice should be processed.

An agreed process was in place which ensured the out-of-hours provider received important clinical information about the needs of patients on the practice's palliative care register. The practice shared information about patients with complex care and treatment needs with the out-of-hours and urgent care providers using a CCG wide system. The practice manager and the administrative worker told us an emergency care plan had been prepared for each patient. They also said this group of patients had access to an emergency telephone number which enabled them to obtain help and support from practice staff. The senior GP was clear about the steps the practice would take should they be dissatisfied with the care and treatment provided by the out-of-hours service.

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the 2014 National GP Patient Survey, published in January 2015, 83% said the GP they visited had been 'good' at involving them in decisions about their care. (This was above both the local CCG and national averages). However, only 56% of patients said the last nurse they saw had been good at involving them in decisions about their care and treatment. This was lower than both the local CCG (70%) and national averages (67%).

The GP we spoke with was aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. They demonstrated a clear understanding of consent and capacity issues and the Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.) They were also able to clearly explain when consent was necessary and how it would be obtained and recorded.

The practice had a consent policy which provided clinical staff with guidance about how, and in what circumstances it would be appropriate to obtain patients' 'expressed' consent to care and treatment. The policy also highlighted how patients' consent should be recorded in their medical notes. However, the policy did not cover what clinical staff should do if they judged that an adult patient might lack capacity to make an informed decision about their care and treatment.

Health Promotion & Prevention

It was practice policy to offer all new patients a health check with the practice nurse. The practice nurse carried out assessments of new patients that covered a range of areas, including past medical history and ongoing medical problems. The practice offered NHS Health Checks to all patients aged between 40 and 75 years of age. The practice manager told us 554 eligible patients had taken up the offer of a NHS Health Checks. (This NHS programme aims to keep patients healthier for longer.)

The practice was good at identifying patients who needed additional support and were pro-active in offering this. For example, there was a register of all patients with dementia. Nationally reported QOF data for 2013/14 showed the practice had achieved 91.2% of the overall points available to them for providing recommended care and treatment to patients with dementia. (This was 1 percentage point below the local CCG average and 2.2 points below the national average). The QOF data also showed that 83.3% of patients with a diagnosis of dementia had had their care reviewed in a face-to-face interview in the preceding 12 months. (This was 4.1 percentage points below the local

Good

Are services effective?

(for example, treatment is effective)

CCG average and 0.5 points below the England average). The practice had systems in place to identify patients who might be at risk of developing dementia which included placing a code on their medical records to alert clinical staff.

Nationally QOF reported data for 2013/14 showed the practice had recorded the smoking status of 86.9% of eligible patients aged over 15. (This was 3.6 percentage points above the local CCG average and 5.2 points above the England average.) The QOF data also showed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The practice website signposted patients to the local NHS Stop Smoking Service and gave details of how patients who used this service were four times more likely to succeed in giving up smoking.

Nationally reported QOF data for 2013/14 showed the practice had protocols that were in line with national guidance, covering such areas as the management of cervical screening. The practice also had a system in place for informing women of the results of cervical screening tests, and for following up patients who failed to respond to a letter from the national screening programme. The practice had obtained 100% of the points available to them for delivering cervical screening services. (This was 1.6 percentage points above the local CCG average and 2.5 points above the England average.) The QOF data also confirmed that the medical records of 80.4% of eligible women included a note that they had received a cervical screening test in the preceding five years.

We did not see any evidence during the inspection of how children and young people were treated by staff. However, neither the patient we spoke to, nor those who completed CQC comment cards, made us aware of any concerns about how staff looked after children and young people.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the National GP Patient Survey, published in January 2015. The evidence from these sources showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received. For example, of the patients who responded to the National Patient Survey: 86% said the last GP they saw, or spoke to, was good at giving them enough time. (This was slightly below the local CCG average (88%) but above the national average (82%); 89% said the last GP they saw, or spoke to, was good at listening to them. (This was above both the local CCG (88%) and national averages (88%); 85% said the last GP they saw, or spoke to, was good at treating them with care and concern. (This was slightly below the local CCG average (86%) but above the national average (82%).

We received 30 completed Care Quality Commission (CQC) comment cards. The feedback received from all patients was very positive. We also spoke with one patient on the day of our inspection. They told us the practice offered a professional service and staff were dedicated to their patients. The patient we spoke with, and those who completed comment cards, confirmed staff treated them well and provided them with good care and treatment.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. There were curtains in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. Patients were able to access a private space if they wished to talk confidentially to reception staff. However, on their CQC comment card, one patient said the reception area did not lend itself to promoting patient confidentiality.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey, published in January 2015, showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example: 83% of respondents said their GP involved them in decisions about their care. (This was above both the local CCG (77%) and national averages (74%); 86% felt the GP was good at explaining treatment and test results. (This was below the local CCG average (88%) but above the national average (82%). Patients who completed CQC comment cards did not raise any concerns in this area and neither did the patient we spoke to on the day of our inspection.

Practice staff had access to translation and interpreter services to help them understand the needs of patients who did not have English as a first language. Providing these services helps to promote patients' involvement in decisions about their care and treatment. However, the practice manager told us these services were rarely used given the ethnic composition of the patient population.

Patient/carer support to cope emotionally with care and treatment

The patient we spoke with, and the patients who completed CQC comment cards, were positive about the emotional support provided by the practice. None of these patients raised any concerns about the support they received to cope emotionally with their care and treatment.

We observed patients in the reception area being treated with kindness and compassion by staff. Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations. The practice had taken steps to identify patients who were also carers. The practice manager told us they intended to use this information to provide this group of patients with extra care and support. The practice website also included information encouraging patients to let the practice know about this. The practice manager told us clinical staff referred patients struggling with loss and bereavement to relevant support groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. They had used a recognised risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled practice staff to identify patients at risk of, for example, an unplanned admission into hospital. The practice kept a register of these patients, and they had written to each patient aged 75 years and over, explaining which GPs would act as their named doctor.

Home visits were carried out by both GPs, as well as the practice nurse. This meant older patients who were housebound were able to receive the care and treatment they needed in their own home. An older person's nurse specialist was attached to the practice. This provided opportunities for clinical staff to engage in partnership working aimed at preventing these patients' unnecessary admission into hospital.

The practice nurse and healthcare assistant were mainly responsible for the delivery of chronic disease management. The practice offered patients with long-term conditions, such as asthma and diabetes, an annual check of their health and wellbeing, or more often where this was judged necessary. The practice manager and administrative worker told us patients were recalled for reviews during which screening tests would be completed and lifestyle advice and guidance given. The administrative support worker told us they carried out annual audits of the practice disease registers to ensure patients received their annual review. Arrangements were also in place to make sure patients who did not attend for a planned review were followed up.

Of the patients who participated in the 2014 National GP Patient survey: 96% said the last nurse they saw was good at explaining tests and treatment. (This was above the local CCG (81%) and national averages (77%); 98% said they had confidence and trust in the last nurse they saw or spoke to. (This was above the local CCG (90%) and national averages (86%).

Nationally reported QOF data for 2013/14 provided confirmation that the practice had established and maintained a register of all patients in need of palliative care and support. The data also indicated that multi-disciplinary team (MDT) meetings took place regularly to discuss and review the needs of each patient on the palliative care register. The GP we spoke with told us these meetings involved healthcare professionals included in supporting patients with palliative support needs, such as MacMillan nurses and health visitors. The QOF score for the provision of palliative care was in line with the local CCG average.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. The practice provided a fortnightly baby clinic, enabling mothers to access recommended childhood immunisations. Pregnant women were able to access a maternity clinic provided by a midwife. Nationally reported data (2013/14) showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These were both above the national averages (i.e. 0.9 and 1.2 percentage points above respectively) and were in line with the local CCG averages. The QOF data also showed antenatal care and screening were offered in line with current local guidelines. The practice website signposted younger patients to information about their health and wellbeing, including guidance on depression in younger people.

Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. The practice manager told us the needs of these children were discussed at the practice's multi-disciplinary team meetings.

The practice offered a full range of immunisations for children. The delivery of childhood immunisations was mostly higher when compared with the overall percentages of children receiving the same immunisations within the local CCG area. For example, MMR vaccination rates for five year old children were 94.9 % compared to an average of 91.5% in the local CCG area. All five childhood immunisations delivered to babies aged 24 months were above each local CCG average. Regular baby clinics were held by the practice nurse, and ante-natal classes were offered by an attached healthcare professional. Appointments were available outside of school hours and the premises were suitable for children and babies. Our data had not identified the practice as being outlier and no level of risk had been attached the delivery of childhood immunisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had planned its services to meet the needs of the working age population, including those patients who had recently retired. It provided an extended hours service until 7:00pm one evening a week, to facilitate better access to appointments for working patients. The practice website provided information about how to book appointments and order repeat prescriptions, including how to do this online. Patients received recommended treatments for commonly found health conditions. For example, nationally reported data indicated that 87.8% of patients aged 16 and between 75 who had hypertension had had an annual assessment of their physical activity during the previous 12 months. (This was 7.1 percentage points above the local CCG average and 11.6 points above the England average).

The practice had taken steps to identify patients with mental health needs, and had made arrangements to meet their needs. For example, there was a register of all patients diagnosed with the mental health conditions covered by the QOF. Nationally reported data (2013/14) showed the practice had achieved 99.4% of the total points available to them for providing recommended care and treatment for patients with mental health needs. (This was 6 percentage points above the local CCG average and 9 points above the national average.) The practice also achieved 100% of the total points available to them for treating patients with depression. (Again, this was 11.1 percentage points above the local CCG average and 13.7 points above the national average.) Patients with mental health needs, both registered and unregistered, were able to access counselling and talking therapies, led by one of the GPs in collaboration with a newly commissioned, local charity. The GP also provided additional services and support for patients with substance misuse problems.

Practice staff worked collaboratively with other professionals and agencies, and where appropriate, shared patient information to ensure good, timely communication of any changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to the care plans of patients who had palliative care or complex healthcare needs. This enabled these services to access important information about these patients and provide appropriate care. The local out-of-hours service provided the practice with feedback about any patient they had seen. A process was in place to make sure this feedback was reviewed by one of the GPs.

Tackle inequity and promote equality

The majority of patients did not fall into any of the marginalised groups that could be at risk of experiencing poor access to health care. The practice manager told us the practice took whatever action it could to meet the needs of patients within this population group. For example, the practice had made suitable arrangements to identify and meet the needs of patients with learning disabilities and those with complex health conditions. Nationally reported data for 2013/14 showed the practice had only achieved 51.1% of the points available to them for providing recommended care and treatment to patients with Down's Syndrome. This was below both the local CCG and England averages. However, we were provided with feedback which explained the QOF data for this area. A substance mis-use clinic was held at the practice and provided patients with access to drug and alcohol counselling.

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. The practice premises had been adapted to meet the needs of patients with disabilities. For example, the nurse's treatment room, a GP consultation room, and the reception area were located on the ground floor. The waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. The practice had a small number of patients whose first language was not English. Practice staff had access to a telephone translation service and interpreters should these be required.

Access to the service

Appointments were available from 09:00am to 12:00pm and between 2:00pm and 6:00pm three days a week and from 09:00am to 12:00pm one day a week. Extended hours were provided on a Tuesday with the practice opening between 09:00am to 12:00pm and between 1:30pm and 7:00pm. Providing extended hours makes it easier for working age patients and families to obtain a convenient appointment.

Patients were able to book appointments by telephone, by visiting the practice or online via the practice website. Patients were offered routine appointments which they could book in advance. Same-day urgent appointments

Good

Are services responsive to people's needs?

(for example, to feedback?)

were also available. The practice manager told us patients requesting a same-day urgent appointment would either be seen by one of the GPs, or a home visit would be undertaken by either a GP or a nurse.

Of the patients who participated in the National GP Patient Survey published in January: 81% said they were satisfied with the practice's opening hours. (This was above both the local CCG average (77%) and the national average (76%); 84% of those who had a preferred GP, said they usually got to see or speak to that GP. (This was above both the local CCG (77%) and national (76%) averages); 98% said they found it 'easy' to get through on the telephone to someone at the practice. (This was above both the local CCG (77%) and national (71%) averages). Neither the patient we spoke with nor any of the 30 patients who completed CQC comment cards, expressed concerns about the practice's appointment system.

The practice's website and leaflet provided patients with information about how to access out-of-hours care and treatment. When the practice was closed there was an answerphone message giving patients the relevant telephone numbers.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints process. The practice website provided patients with information about how to complain, and included a timescale within which a complainant's concerns would be addressed. A suggestions box was available in the waiting area, providing patients with an opportunity to raise concerns anonymously. The patient we spoke with said they had never had to make a complaint but would feel comfortable in doing so. Patients who completed CQC comment cards raised no concerns about how the practice handled complaints. We were told the practice had received no complaints during the last 12 months.

Are services well-led?

Requires improvement

(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 quality care and promote good outcomes for patients. They were able to evidence this in their presentation to us about how they had identified and made plans to meet the needs of the various population groups they served. In addition, the practice had a detailed statement of purpose (SOP) setting out their commitment to patients and providing details of the services they offered to meet patients' needs. In particular, the SOP stated the practice would provide a high standard of care by being 'committed to their patients', acting with 'integrity' and working in partnership with patients and other healthcare professionals to benefit patients. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims.

Governance Arrangements

The arrangements in place for governance did not always operate effectively. Whilst we found evidence that some aspects were good, we identified a number of areas where improvements were needed. For example, the practice had not identified and addressed shortfalls in the system for monitoring vaccine expiry dates, the arrangements for transporting vaccines and the safe handling of prescriptions. Also, the practice had not made sure there were proper arrangements in place for assessing the risk of, and controlling and preventing the spread of infections. There were effective arrangements for dealing with individual patient risks. For example, the practice had used a recognised risk assessment tool to profile patients according to the risks associated with their conditions. However, the arrangements for monitoring, and where appropriate updating, risk assessments, for example, the practice's fire risk assessment, could be strengthened.

There was evidence of effective engagement between the GPs and other members of the practice team. All of the staff on duty met each lunch time to discuss any issues that had arisen which affected the day-to-day running of the practice. The practice manager told us the leadership of the practice encouraged cooperative, supportive and caring relationships amongst staff. The staff we spoke with confirmed this and said they felt respected, valued and supported. Arrangements had been made to improve patient involvement in the day-to-day activities of the practice. The practice had provided patients with opportunities to provide feedback through the promotion of the Friends and Family Test. They were in the process of setting up a patient participation group (PPG).

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured that significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected. The practice had a range of policies and procedures in place governing most of its day-to-day activities. Staff were able to easily access these when needed.

The practice had made arrangements to monitor its clinical performance. Nationally reported Quality Outcomes Framework (QOF) data for 2013/14 confirmed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG), in order to compare data on, for example, emergency hospital admissions. (Peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards.) Audits were carried out in partnership with a prescribing adviser which helped to ensure the GPs prescribed effectively and safely. The senior GP we spoke with confirmed they had carried out a complete audit cycle as part of the work they had undertaken to achieve re-validation. Practice staff carried out regular manual checks of all practice disease registers to make sure patients received recommended levels of care and treatment.

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. All of the staff we spoke with demonstrated a good understanding of their areas of responsibility and took an active role in trying to ensure patients received good care and treatment. They all told us they felt respected, were well supported and would feel comfortable raising concerns with the practice manager or one of the GPs.

Regular practice and multi-disciplinary team (MDT) meetings took place where operational issues and patients'

Are services well-led?

Requires improvement

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

needs were discussed. Staff used these to discuss practice based issues and significant events, and to agree ways of working together to improve how the practice operated and outcomes for patients.

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

The practice had taken steps to set up a PPG. The practice website included information about how to express an interest in joining the group and a notice was on display in the patient reception area. The practice manager told us 18 patients had already expressed an interest in joining the PPG and said the practice hoped to hold its first meeting shortly.

Patients had other opportunities to comment on the services provided by the practice. For example, arrangements had been made for patients to comment on the practice by completing a FFT survey. The practice website included details of how to complete the survey. Of the 76 patients who had participated in the survey, 74 had said they were either 'extremely likely' or 'likely' to recommend the practice to their friends and family. Comments included: 'Can always get appointments at short notice'; 'The service I receive from doctors and staff is excellent and the timescale I receive appointments in is first class'; 'Very friendly surgery, very well run'.

The staff we spoke with felt valued and said they felt they were an equal member of the practice team. They said everyone worked well together to look after patients and meet their needs. This was a small practice with a small team which made it easier for information about the practice and its patients to be shared via the daily lunch-time meetings. The staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues. Staff told us they felt involved in the process of improving outcomes for patients.

Management lead through learning & improvement

The practice provided staff with opportunities to continuously learn and develop. The healthcare assistant told us they had opportunities for continuous learning to enable them to carry out their role. All of the staff we spoke to said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required to carry out their role. We saw evidence confirming the practice nurse had completed training updates to enable them to carry out their chronic disease management role. The senior GP had until recently been the lead GP for research in the local CCG, demonstrating a commitment to improving outcomes for patients. The senior GP also attended a local educational group meeting which they felt helped to promote their continued learning and professional development.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We found that the registered person had not protected patients against the identifiable risks of acquiring a health care associated infection because they did not have effective infection control systems in place. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that the registered person had not protected patients against the risks associated with the unsafe use and management of medicines because there were inadequate arrangements in place for: checking the expiry dates of vaccines; the safe handling of prescriptions; maintaining the 'cold-chain' when transporting vaccines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.