Cornerstone Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Cornerstone practice is a semi-rural dispensing practice providing primary care services to patients resident in Chiseldon and the surrounding villages Monday to Friday. The practice has a patient population of approximately 1,604 of which 21% are over 65 years of age.

We undertook a scheduled, announced inspection on 14 October 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and a CQC pharmacy inspector.

The overall rating for Cornerstone Practice was good. Our key findings were as follows:

- Patients were able to get an appointment when they needed it.
- Staff were caring and treated patients with kindness and respect.
- Staff explained and involved patients in treatment decisions
- Patients were cared for in an environment which was clean and reflected good infection control practices.
- Patients were protected from the risks of unsafe medicine management procedures.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- Patients were treated by suitably qualified staff
- The practice had systems to identify, monitor and evaluate risks to patients.
- GPs and nursing staff followed national clinical guidance.
- The practice had not risk assessed the different responsibilities and activities of staff to determine if they required a criminal records check via the Disclosure and Barring Service. Practice staff who were

Summary of findings

acting in the role of patient chaperone had not a criminal records check. The practice had not undertaken criminal records checks on nurses as part of their recruitment process.

There were areas of practice where the provider needs to make improvements.

Importantly the provider must**:**

- Assess the different responsibilities and activities of staff to determine if they require a criminal records check via the Disclosure and Barring Service and to what level.
- Ensure staff undertaking chaperone duties have a criminal records check via the Disclosure and Barring Service.
- Ensure criminal records checks are undertaken on nursing staff as part of the recruitment process.

The provider should:

- Ensure blank prescription pads are not left unattended in printers in unlocked rooms.
- Include information about other agencies to contact when the patient is not satisfied with the way the practice has handled their complaint.
- Ensure the practice recruitment policy sets out the procedures to follow when recruiting clinical and non-clinical 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 safe as there were areas where improvements should be made. The practice used a range of information to identify risks regarding patient safety. To minimise these risks significant events were reviewed and investigated. Lessons learnt were communicated widely enough to support improvement. Staff understood their responsibilities to raise concerns, and report incidents and near misses.

However the practice did not assess the different responsibilities and activities of staff to determine whether they required a criminal records check via the Disclosure and Barring Service (DBS) and to what level. The practice did not undertake a criminal records check via the Disclosure and Barring Service as part of the nursing staff recruitment process. The one member of administrative staff undertaking chaperone duties had not had a criminal records check via the Disclosure and Barring Service. The practice recruitment policy did not set out the procedures it followed when recruiting clinical and non-clinical staff.

Are services effective?

Good

The practice is rated as good for effective. National quality information showed patient outcomes were average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and applied to practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs had been identified and planned. Staff had appraisals and personal development plans. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. The GP National Patient Survey showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff communicated with patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of its local population and engaged with the NHS England

Summary of findings

local area team (LAT) and clinical commissioning group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and good continuity of care. They said they had a named GP and urgent appointments were available the same day they asked for them. Overall the practice had accessible facilities and was well equipped to treat patients and meet their needs. There was a complaints system with evidence demonstrating the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older patients, including home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had a named GP and structured annual reviews to check their health and medicine needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children who were at risk. For example, there was an alert system on the patients' electronic record. Immunisation rates were relatively high for all standard childhood immunisations. Staff explained how young children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with other health care providers supporting mothers and children.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the

Summary of findings

services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening 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 patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including patients with learning disabilities. Patients with learning disabilities had annual health check and were offered longer appointments if they needed them. The practice had previously provided primary care services to travellers and understood how to support their lifestyle behaviours.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including patients with dementia). All patients recorded on the register as experiencing mental health issues had a care plan in place. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia.

The practice had information to sign-post patients experiencing poor mental health to various support groups and third sector organisations. GPs had received training on how to care for patients with mental health needs and dementia. GPs supported other healthcare providers to provide palliative care for patients with dementia.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with six patients attending the practice. We looked at 22 patient comment cards, feedback from a practice patient survey (2012) and the GP National Patient Survey 2014.

Patients we spoke with were highly satisfied with the care and treatment received. They described staff as friendly, caring and empathetic. Patients gave examples of care where they felt the GP demonstrated patience, good listening and knowledgeable of their needs. This was supported by feedback from the GP National Patient Survey 2014 which indicated 100% of the practice's respondents described their overall experience of the surgery as good or very good. Patients felt their privacy and dignity were respected by staff.

Patients told us they were able to get an appointment on the day they asked for one and could book one with the GP of their choice. Patients told us they had no complaints about the practice and expressed confidence in the practice management to address concerns when they were raised.

Patients felt they were included decisions about their care and felt they were able to ask questions when they had them. They said treatment was explained so they could make informed choices. This was supported by feedback from the GP National Patient Survey 2014 which indicated 94% of patients said their GP was good at explaining tests and treatment.

Patients were satisfied with the cleanliness of the practice.

Areas for improvement

Action the service MUST take to improve

The provider MUST**:**

- Assess the different responsibilities and activities of staff to determine if they require a criminal records check via the Disclosure and Barring Service and to what level.
- Ensure staff undertaking chaperone duties have a criminal records check via the Disclosure and Barring Service.
- Ensure criminal records checks are undertaken on nursing staff as part of the recruitment process.

Action the service SHOULD take to improve

- Ensure blank prescription pads are not left unattended in printers in unlocked rooms.
- Include information about other agencies to contact when the patient is not satisfied with the way the practice has handled their complaint.
- Ensure the practice recruitment policy sets out the procedures to follow when recruiting clinical and non-clinical staff.

Outstanding practice

Cornerstone Practice

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 GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and a CQC pharmacy inspector.

Background to Cornerstone Practice

Cornerstone Practice is a small semi-rural dispensing practice providing primary care services to patients resident in Chiseldon and surrounding villages. The practice shares a purpose built building with another GP practice. All patient services are located on the ground floor of the building. The practice has a patient population of 1,604 patients of which 21% are over 65 years of age.

The practice has one male and one female GP partner. The partners work nine and four GP sessions respectively. They employ a practice manager, two nursing staff, five administrative staff and two dispensing staff. Most staff work part-time. Each GP has a lead role for the practice and nursing staff have specialist interests such as respiratory disease and diabetes.

Primary care services are provided by the practice Monday to Friday during working hours (8am-6.30pm). In addition early morning and later evening appointments are available one day a week. The practice has opted out of the Out of Hour's primary care provision. This is provided by another Out of Hour's provider.

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.

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 patients' needs?
- Is it well-led?

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients

Detailed findings

- Working age patients (including those recently retired and students)
- Patients living in vulnerable circumstances
- Patients experiencing poor mental health (including patients with dementia)

Before our inspection, we reviewed a range of information we held about the service and asked other organisations, such as NHS England local area team, the Swindon Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 14 October 2014. During the inspection we spoke with two GPs, the practice manager, two nursing staff, administration and dispensing staff. We spoke with six patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at practice documents such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

Requires improvement

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 as well as comments and complaints received from patients. Staff we spoke we were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last two years.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were emailed to ensure all were aware of any relevant to the practice and where action needed to be taken.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and learning from significant events, incidents and accidents. Records were kept of significant events that had occurred and actions taken in response. For example, one incident involved the dispensing of a pill organiser box which was not secured and resulted in the displacement of some tablets in the box. The practice responded by implementing an improved checking system and providing additional training for staff. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. Practice training records showed that all staff had received relevant role specific training on safeguarding. We asked GPs, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. The GP had been trained to level three safeguarding children in line with national guidance. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example, patients with dementia.

The lead safeguarding GP was aware of vulnerable children and adults and discussions demonstrated good liaison with partner agencies such as the police and social services.

A chaperone policy was in place and visible in reception and in consulting rooms. Chaperone training had been undertaken by all nursing staff. If nursing staff were not available to act as a chaperone one receptionist had been orientated to the role. They understood their responsibilities when acting as chaperone including where to stand to be able to observe the examination. However, the member of staff undertaking chaperone duties did not have criminal records checks via the Disclosure and Barring Service (DBS).

Patient's individual records were written and managed in a way to promote safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

There was a system for reviewing repeat medications for patients with co-morbidities/multiple medicines. Records demonstrated changes to patients' medicines by other healthcare providers were addressed by the GPs. There was an alert on the electronic records to ensure patients received an annual medicines check.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked including medicines for use in an emergency were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Practice staff had a system to monitor the stock and expiry dates of medicines kept in the doctors bags.

We saw records that noted the actions taken in response to review of prescribing data. For example, patterns of certain antibiotic and inflammatory medicines prescribed in preference to more commonly used alternatives.

Vaccines were administered by nurses using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. Repeat prescriptions were reviewed in line with the practice policy.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We observed this process was working in practice.

We observed blank prescriptions were left unattended in a printer in an unlocked treatment room. This was not in line with national guidance or the practice policy.

The practice held stocks of controlled drugs (medicines that required extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

The practice had established a service for patients to pick up their dispensed prescriptions at the practice and had systems in place to monitor how these medicines were collected. They also had arrangements with other pharmacies to deliver some medicines for house bound patients

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control.

The practice had a new lead for infection control who was up to date with their training. All staff received induction training about infection control specific to their role. Nursing staff had an annual update. We saw evidence the lead had carried out an infection control audit in 2014. There were some areas of improvement which were recorded in an action plan to address outstanding issues. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy for example, the hand washing procedure prior to clinical tasks. There was also a policy for needle stick injury,

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the

environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, the spirometer (a machine to measure how air a patient breathes in and out).

Staffing & Recruitment

Records we looked at contained evidence that not all appropriate recruitment checks had been undertaken prior to employment. Proof of identification, references, qualifications and registration with the appropriate professional body were checked. However, criminal records checks via the Disclosure and Barring Service (DBS) were not completed for nursing staff. Nursing staff worked part time and the practice used DBS checks undertaken by other GP practices the nurses worked for. The DBS checks had were not portable and able to be used by the practice. The practice recruitment policy did not set out the protocols it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups to enable the practice to monitor there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's leave. The GPs used the same GPs as locums when they required cover for their sessions.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We were told that any risks were discussed at practice meetings and within team meetings.

Patients gave us examples of how their GP responded to deterioration in their condition. For example, arranging for admission to hospital following test results. Nursing staff told us if they were concerned about a change in a patient's condition they would seek advice from a GP, make an appointment for the patient to see a GP or undertake initial tests such as blood tests to identify potential causes of the change.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage foreseeable emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of bradycardia (slow heart rate) which may be necessary during the insertion of contraceptive devices. The GP we spoke with told us they had assessed the risk, based on up to date training they had recently attended.

The practice had a policy to manage emergencies requiring an ambulance to transport patients to hospital. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Each risk had mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and

Requires improvement

Are services safe?

access to the building. The document also contained relevant contact details for staff to refer to. For example, details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The staff we spoke with and evidence we reviewed confirmed patient were supported to achieve good health outcomes based on their individual circumstances. We found from our discussions with the GPs and nurses that staff completed assessments of patients in line with NICE guidelines and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, dementia and care of the older adult. The practice nurses supported this work which allowed the practice to focus on specific conditions. For example, screening, monitoring and provision of health education for patients with long term conditions such as respiratory conditions. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

Nursing staff told us the GPs were approachable. They were able to ask for advice and support about patients treatment.

National data showed the practice was in line with referral rates to hospitals and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with a suspected cancer.

The practice demonstrated (QOF 2012/2013) patients prescribed more than four repeat medicines received a structured medicines review every year.

Management, monitoring and improving outcomes for patients

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us the GPs had undertaken seven clinical audits. For example, the use of antibiotics in the treatment of urinary infections and the problems and causes of problems associated with contraceptive coils. Recommendations from the audits had yet to be re-audited to demonstrate that the changes had been implemented and that improvements have been made.

The practice also used the information it collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. For example, the practice was slightly below the clinical commissioning group (CCG) performance for patients with diabetes. The practice had addressed this by employing and training a practice nurse to undertake diabetes checks. The practice met all the minimum standards for QOF 2013/14 in coronary heart disease/asthma/chronic obstructive pulmonary disease (lung disease) and dementia. This practice was not an outlier for any QOF (or other national) clinical targets.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions such as diabetes and respiratory disease. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. The evidence we saw confirmed the GPs had a good understanding of the best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Individual GPs took a lead in a specific clinical area. For example, one GP had undertaken additional training in dementia, whilst the other GP had updated their training in diabetes and offered a joint clinic with a diabetes consultant.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is

Are services effective?

(for example, treatment is effective)

appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that overall the practice was proactive in providing training and funding for relevant courses, for example diabetes and cytology updates.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and smoking cessation. Those with extended roles for example, seeing patients with respiratory disease were also able to demonstrate they had appropriate training to fulfil these roles such as a diploma in managing respiratory conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and Out of Hours information were received both electronically and by post. The GP was responsible for any actions required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patents e.g. those with end of life care needs or patients admitted or discharged from hospital. These meetings were attended by the community matron, district nurses and other relevant healthcare professionals. Decisions about care planning were documented in a shared care record.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. The system was used by community staff to enable patient data to be shared in a secure and timely manner. The Out of Hour's GPs were also able to access the system (read only) for up to date patient information.

Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enabled patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Patients reported that this system was easy to use.

Consent to care and treatment

We found that GPs and nursing staff were aware of the Mental Capacity Act 2005.They understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff described how they enabled patients to understand and make their own decisions. For example, staff stressed the importance of gaining trust, spending time explaining and checking patients' understanding, involving carers with the patient's permission. Nurses referred patients back to a GP when they refused treatment which nurses considered to be in the patient's best interest. One GP had developed an information leaflet about the Mental Capacity Act 2005 to assist staff working in the practice and in other healthcare settings such as local care homes to support patients with impaired capacity.

One GP was trained and had begun to assess patients with impaired mental capacity who might be subject to a deprivation of liberty safeguards authorisation.(Deprivation of Liberty Safeguards

aim to make sure that patients in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom).

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

Nursing staff demonstrated a clear understanding of Gillick competencies. (These competencies help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures such as removal of skin lesions and the insertion of contraceptive intra-uterine devices. A patient's verbal consent was documented in the electronic patient notes.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse.

Are services effective?

(for example, treatment is effective)

Patients were supported to maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75.

The practice had a number of ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. We were told all patients were offered an annual physical health check although not all patients took up the offer.

The practice delivered nurse led smoking cessation clinics to patients. The practice nurse said there was evidence these were having some success as there had been a number of patients who had stopped or reduced their smoking.

The practice's performance for cervical smear uptake was 100% (QOF 2012/13) which was better than the clinical commissioning group average. Performance for national bowel cancer screening in the area was slightly above the average for the CCG (55% compared to 54.8%. National Cancer Intelligence Network 2011/12).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all childhood immunisations was above average for the CCG. For example, 100% of children of 12 months of age received their immunisations.

Feedback from the multi-disciplinary team indicated joint working with the practice worked well in the delivery of care and support during pregnancy and for mothers and babies.

Chlamydia screening self-testing kits were available from the practice for the under 25 age group.

Older patients over the age of 75 years had a named GP. The practice screened patients over 65 years for a particular heart condition as part of meeting the QOF national quality standards and other conditions more prevalent in older patients such as osteoporosis (weakened bones). Older patients and those at high risk were invited for an annual flu vaccination.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent survey data available for the practice on patient satisfaction. This included information from the GP national patient survey (2014) and a small survey of 27 patients undertaken by the practice in 2012. The evidence from all these sources showed patients were satisfied with how they were treated. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The patient reception area was small but away from the waiting room. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey (2014) showed 89% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above the regional average.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patients gave examples of how the GPs and nurses explained care in a way that enabled patients to understand. Patient feedback on the comment cards we received was also positive and aligned with these views. Nursing staff described examples of how patient choice was respected. For example, some patients were offered various treatment options for managing wounds. Staff told us this was to minimise disruption to patients' lifestyle and promote independence.

Some patients accessed the acupuncture service at the practice. The GP who provided the service said it was used for patients with a range of conditions such as migraine and backache.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The GP national patient survey (2014) information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 94% of respondents to the survey reported the last GP they spoke with treated them with care and concern. The patients we spoke to on the day of our inspection and the comment cards we received were consistent with this survey information. For example, these highlighted staff responded compassionately when patients needed help and staff provided support when required.

Are services caring?

Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

GPs could refer their patients to a counsellor who provided one session per week at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice appointment times were 15 minutes long. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to one local care home by a named GP and to those patients who needed one. Patients who were unable to attend the practice for example, older patients and young children, could request a home visit. Patients who were working were able to access GPs or nurse via telephone consultations if they could not attend the practice.

The practice worked collaboratively with other agencies for example, the midwife and community matron and regularly shared information to communicate changes in care and treatment.

The practice had achieved and implemented the Gold Standards Framework for end of life care. Records demonstrated the practice held a register of palliative care patients and met every three months with other healthcare professionals to plan the care for patients with end of life care needs and other long term conditions. There was a system on the patients' electronic record to alert out of hours services to patients dying at home. The GP told us they worked with the palliative care nurses to ensure medicines required at end of life were prescribed and dispensed in a timely manner.

The practice supported patients with long term conditions such as diabetes and respiratory disease by offering annual scheduled reviews for screening, advice and treatment. Patients requiring additional support were seen regularly by the practice nurse. The most vulnerable patients had a personalised care plan, including an agreed plan for crisis management.

The practice has a register of patients with high blood pressure. The Quality and Outcomes Framework (QOF) national quality standards (2012/13) indicated 92.7% patients with high blood pressure had their blood pressure monitored within the last nine months.

The practice delivered a range of enhanced services (services over and above the essential/additional services normally provided to patients). For example, one GP provided monitoring, treatment and support with other health care providers for patients with drug misuse issues. Patients with mental health issues had access to health information in the practice and on the practice website.

One GP had a special interest in supporting patients with dementia. The practice held a register of patients with dementia and provided primary care services to a local care home with a number of residents with dementia.

The practice had a process to implement suggestions for improvements to the way it delivered services as a consequence of feedback from the patients. On the day of the inspection there were no recent negative comments in the patient comments book held at reception. The practice did not have a patient participation group. The practice manager told us patients did not think there was a need. This was confirmed by patients we asked who were confident the practice listened and acted on their concerns.

Tackling inequity and promoting equality

The practice had experience of meeting the needs of different groups in the planning of its services for example, travellers and carers. For example, following up patients who did not attend for immunisations or health checks.

The practice held a list of carers. Carers were offered flu vaccinations in line with government recommendations. The practice manager told us they had regular updates from the carers lead at the clinical commissioning group.

The premises and services had been adapted to meet the needs of patients with disabilities. For example, the practice had made some adjustments to the building for patients with mobility needs such as a ramp to the door and an automated main door to leave the building. However, the main door to the building was not automated and there was no doorbell to summon help. We were told by the practice manager that reception staff knew their

Are services responsive to people's needs?

(for example, to feedback?)

patients' requirements and would offer the necessary assistance. The practice they shared the building with owned had responsibility for the maintenance of the building.

The practice had arrangements in place to support patients with sensory disabilities. For example, there was a hearing induction 'loop system' for patients with hearing difficulties and braille signage in main areas such as the disabled toilet.

The practice had access to online and telephone translation services if necessary.

Access to the service

Appointments were available from 8.30am to 6.30 pm on weekdays. The practice was closed between 1pm to 2pm each day. On a Wednesday afternoon the practice was open, however, appointments were covered by another GP working in the area. In addition later evening appointments were available one day a week.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Further information on the Out of Hours service was provided to patients in the practice leaflet.

Patients were satisfied with the appointments system. Information from the GP National Patient Survey 2014 demonstrated 98% of respondents said their last appointment was convenient and 98% said their experience of making an appointment was good. They confirmed that they could see a GP on the same day they asked for one. They could see another GP if there was a wait to see the GP of their choice. Patients could make an appointment with their GP up to four weeks in advance and up to six weeks in advance with the nurse.

Listening and learning from concerns & complaints

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

The practice had not had any complaints recorded for a number of years. Feedback from patients told us they had no complaints about the practice. Patients we spoke with said they were confident any concerns would be managed appropriately.

There was information on how to make a complaint in the practice leaflet and on the practice website. However, it did not include information about other organisations to contact if the patient was not satisfied with the way the practice handled their complaint.

The practice had a book at reception for patients to record comments, compliments and concerns. We saw the practice manager had provided written responses to the messages left.

Are services well-led?

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

Our findings

Vision and Strategy

The practice vision and values emphasised being a personal, friendly, patient centred practice. This was reflected in staff values and patient feedback. Staff we spoke with gave examples of how knowing their patients, enabled them to provide effective care and treatment which met patients' individual needs. Patients we spoke with described receiving holistic, personalised care delivered by staff at the practice.

Governance Arrangements

The practice had a range of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a range of these policies and procedures and most staff had confirmed they had read the policy and when. The policies and procedures we looked at had been reviewed regularly and were up to date.

The practice manager told us they met with the GPs every two weeks where practice and clinical issues were discussed. Minutes were not kept of these meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure it's performance. The QOF data for this practice showed overall it was performing in line with local and national standards. QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes, for example, the management of diabetic patients.

The practice had completed some clinical audits, for example, the prescribing of antibiotics for urinary tract infections. However, recommendations from the audits had yet to be re-audited to demonstrate that the changes had been implemented and that improvements had been made.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a range of issues.

Leadership, openness and transparency

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

Staff told us that there was an open culture within the practice. They said practice issues were addressed on an informal basis or by email. They said this was a practical way of keeping informed of practice issues as most staff worked part time and attending meetings was not always feasible due to other work commitments. Staff we spoke with were satisfied with this way of working. The practice nurse met with the practice manager every week to update on practice issues.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice gathered feedback from patients. The last patient satisfaction survey in 2012 addressed the availability of practice appointments. 26 of the 27 respondents were satisfied with the practice appointment system. There were no negative comments for the practice. The practice also used feedback from the GP National Patient Survey. The data demonstrated patient satisfaction was above the regional average for most areas surveyed.

The practice did not have a patient participation group (PPG). The practice manager said patients when asked did not feel it was necessary to have a group to represent their views. The patients we spoke with confirmed they felt there views on the quality of the services were listened to and addressed appropriately.

The practice had gathered feedback from staff through general discussions and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us they required specific equipment to undertake their role and this was provided. Another member of staff told us that they had asked for specific training to progress in their role. We saw this was on their personal development plan for 2014/2015. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Are services well-led?

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

The practice had a whistle blowing policy which was available to staff.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and education. We looked at five staff files and saw that regular appraisals took place which included a personal development plan

The practice had completed reviews of significant events and other incidents and shared the findings with staff via email and meetings. Meeting records, for example, showed improved refrigerator temperature monitoring following the breakdown of the vaccine refrigerator.

Overall evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated management did lead through learning and improvement. For example, although audit cycles were not completed, action plans were reviewed and communication across the whole staff group although often informal did take place. This promoted the identification of potential risks to both patients and staff.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider was in breach of Regulation 21(b) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation.** **Patients who used the services and others were not protected because the provider had not ensured** **that information specified in schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity, and such information as is appropriate.** **The provider had not assessed the different responsibilities and activities of staff to determine if they were eligible for a DBS check and to what level.** **The provider had not ensured recruitment procedures were in line with the national policy on criminal record checks. Staff undertaking chaperone duties had not had a criminal records check. The practice did not undertake criminal records checks when nursing staff were recruited.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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