Dorking Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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

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Overall summary

Letter from the Chief Inspector of General Practice

The practice has an overall rating of good.

We carried out an announced comprehensive inspection at Dorking Medical Practice on 16 June 2015. Dorking Medical Practice provides personal medical services to people living in the Dorking area. At the time of our inspection there were just under 9,600 patients registered at the practice with a team of four partner GPs, four salaried GPs, practice nurses, healthcare assistants, a team of receptionists and administration staff, a dispensing team and a practice manager. The practice has a smaller dispensing branch surgery (Hillside Surgery) which we did not inspect, however we did review the dispensary service at this location.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It requires improvement for providing safe services, specifically in relation to medicines management and cleanliness and hygiene. We found the practice was delivering a good service to all its population groups.

At the time of the inspection only two of the partner GPs were registered with CQC. We spoke with the practice manager in relation to this, who informed us they were in the process of submitting the required forms to CQC. We saw evidence that confirmed this was the case.

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.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.

Summary of findings

- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients spoke positively about how they were treated by staff and we noted that this was consistent with comment cards and patient survey feedback.
- Information about services and how to complain was available and easy to understand.
- Most patients said they found it easy to make an appointment with the GP and that urgent appointments were available the same day.
- The practice was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The practice issued “calendar packs” rather than “blister packs” for high risk patients or high risk medicines, to assist patients in taking the correct dosage on the correct day.
- The practice had a repeat prescribing system which allowed repeat prescriptions which had previously been authorised for three or six cycles to be re-authorised by practice staff.
- The practice had created a consistent approach to the repeat prescribing system

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

The Provider must;

- Ensure that medicines are stored safely so as not to allow unauthorised access and that all medicines are reviewed for expiry dates.
- Ensure that the appropriate action taken has been recorded where fridge temperatures are above the recommended temperature range
- Ensure that handwritten prescriptions are tracked through the practice at all times.
- Ensure that the cold chain for medicines has been validated
- Monitor cleaning standards throughout the practice and ensure the infection control audit accurately reflects the standard of cleaning and cleaning records.

In addition the provider should:

- Include advocacy and ombudsman details in information given to patients about how to make a complaint.

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 as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Audits, significant events and complaints were reviewed and learning discussed with clinical staff. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. We found that some medicine refrigerators were not secure allowing unauthorised access and appropriate action had not been taken when fridge temperatures were recorded above the recommended temperature range. The cold chain for medicines had not been validated and four items were past their expiry date. We also noted that handwritten prescriptions were not tracked through the practice at all times. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The standards of cleaning at the practice were inconsistent and we found that some high surfaces had not been cleaned adequately.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice was able to demonstrate that appraisals and personal development plans had taken place for all staff. Staff worked with local multidisciplinary teams to provide patient centred care.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with

Summary of findings

kindness and respect, and maintained confidentiality. During the inspection we witnessed staff interacting with patients in a way that was respectful and friendly. The practice advertised local support groups so that patients could access additional support if required.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. However, we noted that posters displayed, explaining how patients could complain, did not include details for advocacy or the ombudsman service which could help to support patients through the complaints system. There was evidence of shared learning from complaints with staff and patients. The practice had arrangements in place to support patients with disabilities. Home visits and telephone consultations were available.

Are services well-led?

Good

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

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 that outcomes for patients were positive for conditions commonly found in older patients. There were arrangements in place to provide flu and pneumococcal immunisations to this group of patients. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available. The practice offered personalised care to meet the needs of the older patients in its population. It was responsive to the needs of older people, and could offer home visits. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients. Repeat prescriptions could be requested by email, practice web page, via the community pharmacy, hand, post or fax. Prescriptions could be written for seven days duration or less when clinically required. The community pharmacy or practice could provide Monitored Dosage Systems. Provided the practice had written authority, other people like the "volunteer drivers" could collect medicines and prescriptions. Where medicines were prescribed weekly the day of the week the medicine was to be started was agreed with the patient and then stated on the prescription.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness. Repeat prescriptions could be requested by email, practice web page, via the community pharmacy, hand, post or fax. The practice had the support from a nurse specialist in diabetes who ran a clinic at the practice twice a week.

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Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were average for all standard childhood immunisations. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered contraceptive implants. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Practice staff had received training on safeguarding children relevant to their role and knew how to respond if they suspected abuse. Child safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be seen on the day.Repeat prescriptions could be requested by email, practice web page, via the community pharmacy, hand, post or fax.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of 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 services it offered to ensure these were accessible, flexible and offered continuity of care. Patients were able to request a GP to telephone them instead of attending the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.Repeat prescriptions could be requested by email, practice web page, via the community pharmacy, hand, post or fax.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. The practice offered longer appointments for patients when required. 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 normal working hours and out of hours. Translation services were available for patients who did not use

Summary of findings

English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Accessible toilet facilities were available The practice supported patients who were registered as a carer. Repeat prescriptions could be requested by email, practice web page, via the community pharmacy, hand, post or fax. Prescriptions could be written for seven days duration or less when clinically required. The community pharmacy or practice could provide Monitored Dosage Systems. Where medicines were prescribed weekly the day of the week the medicine was to be started was agreed with the patient and then stated on the prescription. The practice had recognised the need for a 'hard to reach' population group to be able to access appointments on the same day. This prevented this group failing to turn up for appointments and enabled the practice to offer opportunistic help and advice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Patients with severe mental health needs had care plans and new cases had rapid access to community mental health teams. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations. The practice worked with the local mental health team and consultants. Repeat prescriptions could be requested by email, practice web page, via the community pharmacy, hand, post or fax. Prescriptions could be written for seven days duration or less when clinically required. The community pharmacy or practice could provide Monitored Dosage Systems. Where medicines were prescribed weekly the day of the week the medicine was to be started was agreed with the patient and then stated on the prescription.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 25 comment cards which contained positive comments about the practice. We also spoke with five patients on the day of the inspection and two members of the patient participation group.

We reviewed the results of the national patient survey from 2014 which contained the views of 106 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 72% of respondents found it easy to get through to the practice by phone with 90% saying they were able to get an appointment to see or speak to someone the last time they tried and 95% said they had an appointment convenient to them. When asked if the last GP they saw or spoke with was good at giving them enough time 85% said yes and 97% said they had confidence and trust in the last GP they saw or spoke with. All of these scores were above the average for local clinical commissioning group (CCG).

We reviewed the practice's results for the Friends and Family Test from September 2014 to May 2015. We noted that 116 patients out of 128 were either likely or very likely to recommend the practice.

We spoke with five patients on the day of the inspection and reviewed 25 comment cards completed by patients in the two weeks before the inspection. Comments we reviewed and the patients we spoke with were positive about the practice and the care they received. They told us that they were respected, well cared for and treated with compassion. Patient's described the staff and GPs as excellent and told us that they were listened to by all staff. Patients told us they were given advice about their care and treatment which they understood and which met their needs. They described the GPs and nurses as kind and told us they always had enough time to discuss their medical concerns.

Areas for improvement

Action the service MUST take to improve

- Ensure that medicines are stored safely so as not to allow unauthorised access and that all medicines are reviewed for expiry dates.
- Ensure that the appropriate action taken has been recorded where fridge temperatures are above the recommended temperature range
- Ensure that handwritten prescriptions are tracked through the practice at all times.
- Ensure that the cold chain for medicines has been validated
- Monitor cleaning standards throughout the practice and ensure the infection control audit accurately reflects the standard of cleaning and cleaning records.

Action the service SHOULD take to improve

- Include advocacy and ombudsman details in information given to patients about how to make a complaint.

Dorking Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead Inspector. The team included a GP, a Practice Manager, a pharmacy lead and a CQC Manager.

Background to Dorking Medical Practice

Dorking Medical Centre is a semi-rural practice which offers personal medical services to the population of the Dorking area. The practice has a smaller branch surgery (Hillside Surgery) which we did not inspect, however, we did review the surgeries dispensary service at Hillside Surgery. The practice is involved in the education and training of doctors. There are approximately 9,600 registered patients.

The practice is run by four partner GPs. The practice is also supported by four salaried GPs, four practice nurses, a nurse team leader, three healthcare assistants, a team of receptionists, administrative staff, dispensing staff and a practice manager. At the time of the inspection only two of the partner GPs were registered with CQC. We spoke with the practice manager in relation to this, who informed us they were in the process of submitting the required forms to CQC

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and holiday vaccinations and advice.

Services are provided from two location:

New House Surgery, 142a South Street, Dorking, RH4 2QR

and

Hillside Surgery, Boxhill Road,Tadworth, Surrey, KT20 7JG

We completed a comprehensive inspection at New House Surgery and reviewed the dispensary at Hillside Surgery.

New House Surgery is open Monday to Friday 8am – 6:30pm with extended hours Tuesday and Wednesdays 6:30pm – 8:30pm

Hillside Surgery is open Monday to Friday 8:30am to 1pm with afternoon opening on a Monday 4pm to 6pm and Tuesday and Wednesday 3pm to 5pm

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice is a GP training practice and supports new registrar doctors in training. At the time of inspection there were no doctors who were receiving general practice training.

The practice has a higher number of patients between 40 and 85 years of age than the national and local clinical commissioning group (CCG) average, with a significant higher proportion of patients above 45 - 49 and over 80 years of age than the national average. There are significantly fewer patients aged 0- 39 years of age than the national average. There are a lower number of patients with a caring responsibility and the percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the average for England.

Why we carried out this inspection

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

Detailed findings

comprehensive inspection of the practice, on 16 June 2015, 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 was 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. The practice had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the Surrey Downs Clinical Commissioning Group (CCG). We carried out an announced visit on 16 June 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, healthcare assistants and administration staff.

We observed staff and patients interaction and talked with five patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 25 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

We saw that the practice was able to demonstrate a track record for maintaining patient safety. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Medicines recalls were received by the practice manager and dispensary staff, who would action the alert if required.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and we reviewed records from the last 12 months. 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 meetings and felt encouraged to do so.

Staff used significant event forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw records for incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result.

National patient safety alerts were disseminated 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 discussed at meetings and if needed during one to one meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments.

There was a chaperone policy, which was visible on the waiting rooms noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, could be used as a chaperone.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

Requires improvement

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators. These were stored securely and were only accessible to authorised staff. However we noted three refrigerators which were not secure, allowing unauthorised access. Room temperatures were not monitored or recorded and whilst refrigerator temperature checks were carried out one set of records indicated that the refrigerator had been above the recommended temperature range. There was no evidence that actions had been taken as a result. Vaccines were transported from the main practice to the branch surgery using a "cool bag" and "ice packs". However, the "cold chain" had not been validated.

The practice met regularly with the clinical commissioning group (CCG) pharmacist. Processes were in place to check medicines were within their expiry date and suitable for use including expiry date checking. Expired and unwanted medicines were disposed of in line with waste regulations. Most of the stock medicines we checked were within their expiry dates. This was with the exception of for four items which were past their expiry date.

The nurses used Patient Group Directions (PGDs) to administer vaccines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated. The health care assistants administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Whilst most prescriptions were for 28 days, prescriptions for shorter durations were issued where clinically appropriate and medicines taken weekly were prescribed for a specific day that had been agreed with the patient.

All non-dispensing and repeat dispensing patient prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. Dispensing staff had all completed appropriate training and had their competency annually reviewed. Both blank prescription forms for use in printers and those for hand written prescriptions were stored in accordance with national guidance. However, only the prescription forms used in printers were tracked through the practice at all times.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

We saw that the practice issued "calendar packs" rather than "blister packs" for high risk patients or high risk medicines, to assist patients in taking the correct dosage on the correct day. We noted that practice staff were able to re-authorise repeat prescriptions where previously three or six cycles had already been prescribed. Practice staff then placed a note on the prescription for the GP to review prior to signing. The practice had produced an agreed set of information notes that could be placed onto repeat prescriptions for the GPs to read, therefore ensuring a consistent approach to the repeat prescribing system by staff.

Cleanliness and infection control

Patients we spoke with or who had completed comments cards told us they found the practice clean and had no concerns about cleanliness

However, the standards of cleaning at the practice were inconsistent. We found that most areas within the practice were cleaned to a high standard. We found that some high surfaces had not been cleaned within the treatment rooms and observed dust on some of the GP models used to explain medical conditions. We also noted that there was dirt and debris underneath a moveable chest of draws. We saw daily, weekly and monthly cleaning records were in place. The monthly cleaning records we reviewed showed gaps in areas that had not been cleaned. For example, damp wipe of desk surfaces, and high and low surfaces.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that the lead had carried out regular audits with the most recent being in May 2015. However, the infection control audit had failed to pick up the gaps in the cleaning records to address this issue.

Requires improvement

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to. This enabled staff to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Notices about hand hygiene techniques were 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 bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

The practice manager ensured all electrical equipment had received a portable appliance check to ensure the equipment was safe to use. Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

A practice nurse carried out monthly checks on emergency equipment such as the oxygen and defibrillator.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment requirements policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and could be available for annual leave and sickness absence cover. 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 and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that any risks were discussed at practice meetings and within team meetings. For example, we saw minutes from the complaints and significant events meeting where issues were discussed and actions needing to be taken were recorded.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. The practice had available emergency equipment available. For example, oxygen or an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in the practice and; all staff knew of the locations. 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.

An emergency and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included

Requires improvement

Are services safe?

power failure, staff shortages and access to the building. The document also contained relevant contact details for staff to refer to. We noted the plan also referred to neighbouring practices who could help in an emergency.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that fire alarms were regularly checked. Staff also told us and we saw evidence that they had practiced an evacuation of the building in a fire drill in the last six months.

Good

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. We also noted that a diabetic nurse specialist visited the practice twice a month to help support patients.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. Patients with specific needs were reviewed to ensure they were receiving appropriate treatment and regular review. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice identified two per cent of patients with complex needs who were at greater risk of admission to hospital as part of a national scheme to reduce avoidable unplanned admissions to hospital. The practice ensured all these patients had a care plan in place. If any of the patients identified were admitted to hospital the GPs followed up their admission within three days of receiving the hospital discharge letter. We saw an example of the care plans in place and found them to be comprehensive. It showed us that patients with complex medical needs had a named GP to support continuity of care.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

Clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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 and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had received the flu jab and 90% had a record of a foot examination in the

preceding 12 months. We also noted that 92% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional; including an assessment of breathlessness in the preceding 12 months and that 100% of patients aged 75 or over with a fragility fracture, were currently being treated with an appropriate bone-sparing agent. We also noted 84% of asthma patients, on the register, had an asthma review in the preceding 12 months that included an assessment of asthma control. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice's prescribing rates were similar to national figures There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had made use of the gold standards framework for end of life care. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. Patients were also highlighted on the practice computer system so that their care could be prioritised.

The practice participated in local benchmarking run by the clinical commissioning group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and policies and procedures. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, safeguarding children and vulnerable adults. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. All the staff we spoke with told us they felt their appraisal was effective and a positive experience. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the healthcare assistants we spoke with told us they had first been employed as a receptionist and had taken on extra training in order to become a healthcare assistant.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Relevant staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. We noted that the practice held monthly palliative care meetings. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. On the day of the inspection our GP specialist was able to attend the palliative care meeting. They told us that they felt the system worked well and staff remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used a referral system for patients requiring specialist treatment. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

There was a practice website with information for patients. The website told patients about the services offered by the practice and signposted them to services available and latest practice news. The practice produced a regular patient newsletter which we saw was available in the waiting rooms for patients to read and take away.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Systems were in place to support patients to make decisions. Clinical staff demonstrated an understanding of Gillick competencies, which help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

There was a practice policy for documenting consent for specific interventions. A patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. There was evidence that care plans were appropriately reviewed and that they contained details of the patient's references for treatment and decisions. Data we reviewed showed that 80% of patients diagnosed with dementia had their care reviewed in a face-to-face review in the preceding 12 months and 89% of patients with a diagnosis of depression had a care review between ten and 35 days after their diagnosis.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use

Good

Are services effective?

(for example, treatment is effective)

their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Staff we spoke with told us these checks had helped to identify patients at risk of high blood pressure or high cholesterol. Processes were in place to refer to the GP when required.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of patients with poor mental health and 84% had seen a GP for an annual review and had a comprehensive care plan agreed.

The practice had identified the smoking status of 82% of patients over the age of 15 and we noted that 95% of those patients recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. The practice's performance for cervical smear uptake was 90%, which was higher than the national average at 82%. We noted that there was a mechanism in place to follow up patients who did not attend screening programmes.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting areas and the practice website referenced websites for patients looking for further information about medical conditions. The practice had two blood pressure monitoring machines in its waiting rooms. Patients were encouraged to use the machines and discuss the results with their GP.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 92% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 87% of practice respondents saying the GP was good at listening to them and 94% saying the same about the nurses. When asked if the last GP or nurse they saw or spoke to was good at giving them enough time 85% agreed the GPs gave them enough time and 92% thought the nurses did. We also noted that 97% of patients that had responded said that they had confidence and trust in the last GP they saw or spoke to and 98% said the same about the last nurse they saw.

We also spoke with five 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. Patients said they felt the practice offered an efficient service and staff were friendly, considerate and caring. They said staff treated them with dignity and respect. Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards and all were positive about the service experienced

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains / screens 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 saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice main switchboard was located away from the reception desk and patients waited for their appointments in a separate waiting area. This prevented patients overhearing potentially private conversations between patients and reception staff. We noted that music was played in the waiting areas which helped to protect patient privacy. Patients were able to book in using an electronic booking in system which also allowed for a patient confidentiality. Staff were able to describe practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view and asking patients if they would like to speak in a private room away from the front desk, if required.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. We noted that reception staff had received training in conflict resolution.

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 showed 79% of practice respondents said the GP involved them in care decisions compared to the clinical commissioning group average of 81%. When asked if they felt the GP was good at explaining treatment and results 85% said yes compared to the clinical commissioning group average of 86%.

Patients we spoke with 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 85% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 92% of patients said the nurses were also good at treating them with care and

Good

Are services caring?

concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting rooms, on the TV screen and patient website also told patients how to access 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.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's 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 in the way services were delivered. For example, the practice had recognised the need for a hard to reach population group to be able to access appointments on the same day. This prevented this group failing to turn up for appointments and enabled opportunistic advice to be given to help maintain or improve mental, physical health and wellbeing.

Patients were able to book appointments on the day or two weeks in advance. We also saw that the practice ran a duty doctor rota. The duty doctors' role was to ensure that patients were seen in an emergency on the same day and to run a, by appointment, sit and wait clinic from 4pm to 6pm. We noted that patients had numerous ways to request repeat prescriptions. This included email, via the practice web page, via the community pharmacy, by hand, post or fax.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had received comments that patients sometimes waited a long time for calls to be answered during peak times of the day. In response to this the practice had moved the phone lines away from the front desk and had dedicated staff to answer calls during these times.

Longer appointments were available for patients who needed them and for those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary. Patients were able to book appointments and order repeat prescriptions on line.

The practice supported patients with complex needs and those who were at risk of hospital admission. The practice worked closely with district nurses, health visitors and the palliative care team. Personalised care plans were produced and were used to support patients. The practice had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term condition had their health reviewed in an annual review. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health. Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up. Post natal and six week check were provided and the midwife held two clinics each week at the practice. The health visitor also ran two clinics each month for eight week baby checks, first immunisations and a general advice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required. We noted that staff had received equality and diversity training and that there was a policy in place to support staff. The practice had a hearing loop for those patients with hearing impairments.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was purpose built and situated over two floors. Several chairs had arm rests to aid patients when getting up from their seats. The downstairs waiting area was accessible for wheelchairs and mobility scooters. For those patients with limited mobility ground floor treatment and consulting rooms could be used. Accessible toilets were available for all patients attending the practice.

Access to the service

The practice appointment system offered patients the opportunity to have pre-bookable and same day appointments, urgent appointments, call backs and home visits by the doctor. New House Surgery was open Monday to Friday 8am – 6:30pm with extended hours Tuesday and Wednesdays from 6:30pm – 8:30pm. Hillside Surgery was open Monday to Friday 8:30am to 1pm with afternoon opening on a Monday 4pm to 6pm and Tuesday and Wednesday 3pm to 5pm.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients could book appointments by telephone, face to face or online. Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included details of how to arrange urgent appointments and home visits.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of hour's service. 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. Information on the out-of-hours service was provided to patients.

Patients were mainly satisfied with the appointments system. Patients we spoke with told us that they found it easy to get through on the telephone to book an appointment although one patient commented that they had been unable to get an on the day appointment at Hillside Surgery. We noted data from the national patient survey 2014 that 72% of patients thought it was easy to get through to the practice by phone and 95% of respondents said the last appointment they received was convenient**.**

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. We saw that information was displayed in the waiting areas and on the practice website. However, we noted that there was not a complaints leaflet and information provided to patients did not include reference to advocacy or ombudsman details to help support patients through the complaints system. The practice had various ways that patients could raise concerns or complaints. In the waiting area there were comment boxes and the practice was taking part in the Friends and Family test with suggestion boxes available within the patient waiting areas. This invited patients to provide feedback on the service provided, including complaints. None of the patients we spoke with had ever had cause to complain

We looked at complaints received in the last 12 months and found these were all discussed, reviewed and learning points noted. We saw these were handled and dealt with in a timely way. We noted that lessons learned from individual complaints had been acted on. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff. The culture of the practice was that of openness and transparency when dealing with complaints and the practice tried to encourage patients to share their opinions.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the aims and objectives values in their statement of purpose. The practice aims and objectives included to be a patient centred organisation and to ensure a high quality, safe and effective service and environment. The aims and objectives also included a focus on improving clinical governance and evidence based practice, improving communication between the practice and the patients and to recruit, retain and develop a highly motivated and appropriately skilled workforce.

The practice's ethos was to strive towards a partnership between patients and health professionals based on mutual respect, holistic care, continuity of care and the therapeutic relationship, learning and training.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of the policies and procedures and found they were up to date and held relevant information for staff. This included the confidentiality protocol, infection control and the whistleblowing policies.

There was a clear leadership structure with named members of staff in lead roles. For example, one of the partners was lead for palliative care and another for family planning, a nurse and the practice manager were the leads for infection control and two GPs were the lead for safeguarding adult and children. The leads had their roles clearly defined and were proactive in delivering changes or updating information where necessary. For example, the lead nurse for respiratory illnesses had uploaded inhaler technique leaflets onto the in house computer systems so that staff could have access to this information and could be printed for patients. We spoke with 16 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We found the senior management team and staff continually looked to improve the service being offered, by recognising staff skills and utilising them to benefit the practice and patients. For example, one staff member who had good IT skills had been asked to become the admin co-ordinator to help support the practice with things such as audits. A healthcare assistant who was also part of an externally run weight reduction service, was asked to support patients with weight management.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw that QOF data and audits were regularly discussed at monthly team meetings and action taken to maintain or improve outcomes. The practice regularly submitted governance and performance data to the clinical commissioning group (CCG).

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a recent risk assessment for health and safety and for infection control.

The practice held regular meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. We were shown the staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

We saw from minutes that partner meetings were held every week and that there was a monthly clinical meeting which was used to review significant events, incidents and accidents. The practice nurses and healthcare assistants met every six weeks. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and were supported if they did. Staff said they felt respected, valued and supported by the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the virtual patient participation group (PPG), surveys and complaints received. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We spoke with a member of the PPG and they felt positive about the role they played and told us they were engaged with the practice. (A virtual PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care mainly through e-mail rather than face to face meetings).

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice had various ways that patients could leave comments. In the waiting area there were comment boxes and the practice was taking part in the Friends and Family test with suggestion boxes which invited patients to provide feedback on the service provided. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff meetings where guest speakers and trainers attended. For example, the healthcare assistant told us that speakers regularly attended their nurse meetings.

All staff received an induction when they first started work. Staff we spoke with told us they were given a buddy to work with and had one to one meetings with a senior staff member to discuss their progress. They told us they had a meeting after three months to ensure they felt competent in doing the role and could discuss any further training requirements. We saw the practice used an induction check list to record that staff were signed off on various subjects. For example, for newly recruited salaried GPs a check list was used that included local referral processes and the location of emergency drugs and equipment.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients and staff. For example, we noted that the practice had organised additional training for staff after having received complaints regarding prescription errors. Minutes of the clinical meeting showed that all staff, including GPs were reminded of correct procedures and measures put in place to prevent the situation arising again. Staff we spoke with told us there was a no blame culture within the practice and that concerns or complaints raised were used for reflection and learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure the safe storage and recording of medicines. Due to some medicine refrigerators not being secure and possibly allowing unauthorised access, not validating the cold chain, and four items past their expiry date. As well as hand written prescriptions not being tracked through the practice at all times and not recording the appropriate action taken when fridge temperatures were recorded above the recommended temperature range. This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had failed to ensure that all areas within the premises and some display models were kept clean and had failed to appropriately monitor the level of cleanliness. This was a breach of regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014