Dr Timothy Ryder

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr T Ryder (Ruskington Medical Practice) on 4 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. 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. The practice was proactive in providing training and staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Some patients said they found difficulty in making an appointment but urgent appointments were available on the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt well supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Manage blank prescription pads in accordance with national guidance to ensure their security.
- Ensure sharps bins are labelled and emptied when three quarters full.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Staff were aware of their responsibilities with regard to safeguarding and we saw examples where concerns had been raised appropriately.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were overall at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People'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 had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

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 kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. There had been some patient dissatisfaction with the appointment system but the practice had responded and had started to implement changes to the appointment system which were starting to become embedded. Urgent appointments were available on the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain

Summary of findings

was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We saw evidence of learning from complaints being shared with staff and other stakeholders.

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 well supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There was a named accountable GP for patients over 75.

Care plans agreed and in place for all care and residential home residents with a named care co-ordinators within the reception team. The practice held immunisation campaigns for flu, shingles, and pneumonia and carried out pulse checks at flu clinics for over 65's to identify potential atrial fibrillation in order to prevent strokes. Flu clinics were also attended by Age UK.

The practice provided a medication delivery service with weekly dossett boxes. The delivery driver reported back any concerns about patients to the practice. There were monthly multi disciplinary team meetings to discuss at risk patients and the practice actively engaged with the neighbourhood team. In order to support carers there were regular links to voluntary services such as Well-being service, Age UK and Carers Connect.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. There were effective recall processes in place for structured annual reviews to check that patients 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. There was a clinical lead in place for all conditions. Care plans were agreed with and in place for chronic obstructive pulmonary disease (COPD) patients. A practice nurse and health care support worker were available during the practice's extended evening hours to provide flexible appointments for reviews.

Summary of findings

The practice loaned out equipment to patients such as blood pressure monitors to use at home. Medication dossett boxes were available for patients with complex cases. The practice hosted the diabetic retinopathy van and an INR clinic in order to save patients travelling further afield.

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, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. 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, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (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. The practice offered online appointment booking and prescription ordering as well as a full range of health promotion and screening that reflected the needs for this age group. There was a nurse practitioner led minor ailment clinic, same day emergency triage and telephone consultations were available for results and advice.

The practice offered extended hours until 8pm on alternate Tuesdays and Thursdays which included appointments with GPs, nurse practitioners, practice nurses and health care support workers. There was an in house physiotherapy service and referrals could be made to smoking cessation clinics, weight watchers and exercise facilities.

Medication could be delivered to local post offices which enabled patients to collect at weekends.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had four learning disability homes attached to the practice and therefore a higher than average number of patients with a learning disability. One of the nurses was the learning disability lead within the practice and worked closely with the community health liaison nurse and carried out annual health checks at the homes. Other learning disability patients were invited to the practice for a health check and longer flexible appointments were offered in order to reduce distress when attending the practice. There was a named point of contact in the dispensary for ordering medication for learning disability homes.

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

The practice operated a communication board in order that all staff were aware of vulnerable patients who may need extra support.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Some patients with poor mental health had care plans in place including dementia care plans. The practice had regular contact with the community psychiatric nurse.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including the local 'wellbeing service. Staff had received training on how to care for people with mental health needs and dementia. Two staff had trained to be 'dementia friends.' The practice carried out medication monitoring by means of only issuing weekly prescriptions and the use of dossett boxes. There was a system in place for carrying out annual mental health reviews and GPs booked follow ups themselves for either face to face or telephone appointments.

Summary of findings

The senior GP referred patients directly to the community mental health team rather than relying on self referral from the patient. Following this the community psychiatric nurse would make contact with the patient within two weeks.	

Summary of findings

What people who use the service say

The practice had carried out a patient survey of 118 patients between February and March 2014 in conjunction with the patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The survey showed patients felt they were generally satisfied with how they were treated and that this was with compassion, dignity and respect. The data from the national GP patient survey in 2013 to 2014 showed varying results. The satisfaction scores on consultations with doctors showed that 83% of practice respondents said the GP was good at treating them with care and concern which was in line with the national average. It also reflected that 66% of patients would describe their overall experience of the surgery as good which was below the national average.

We received seven comment cards on the day of our inspection and the majority were positive about the service experienced. Patients said staff treated them with dignity and respect. The two comments which were less positive reflected dissatisfaction with making an appointment and lack of involvement in care decisions. We also spoke with eight 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. Some told us the service had improved over the last year and others still found it difficult to get through to the practice by phone to make an appointment.

Areas for improvement

Action the service SHOULD take to improve

- Manage blank prescription pads in accordance with national guidance to ensure their security.
- Ensure sharps bins are labelled and emptied when three quarters full.

Dr Timothy Ryder

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 and another CQC inspector.

Background to Dr Timothy Ryder

Dr T Ryder (Ruskington Medical Practice) provides primary medical services to approximately 8,000 patients in Ruskington and the surrounding villages. The practice has a dispensary which dispenses medicines to patients registered with the practice who live more than a mile from their nearest pharmacy.

At the time of our inspection the practice was staffed by one male GP, a practice manager, a full time salaried female GP and a part time salaried GP, two nurse practitioners, two practice nurses, two health care assistants, a practice manager, a dispensary manager, two dispensers, two dispensing assistants, a reception manager and a team of reception and administration staff.

The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is open from 8.00am to 6.30pm. Appointments are available from 8.30am to 6.30pm on weekdays and until 8.00pm on alternate Tuesdays and Thursdays. The practice also operated a nurse practitioner led minor ailment clinic between 8:30am and 10:30am on weekdays.

The practice is located within the area covered by NHS South West Lincolnshire Clinical Commissioning Group (SWLCCG). The CCG is responsible for commissioning services from the practice. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

NHS South West Lincolnshire Clinical Commissioning Group (SWLCCG) is responsible for improving the health of and the commissioning of health services for 128,000 people registered with 19 GP member practices and the surrounding villages.

The practice has a website which we found provided patients information about the practice and the services they provide and also gives links to further external sources of information. Information on the website could be translated in many different languages by changing the language spoken. This enables patients whose first language was not English to access the information provided by the practice.

We inspected the following location where regulated activities are provided:-

Dr T Ryder (Ruskington Medical Practice) 6, Brookside Close Ruskington, Sleaford Lincs. NG34 9GQ.

Dr T Ryder has opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided by Lincolnshire Community Health Services NHS Trust.

Why we carried out this inspection

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 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. These groups are:

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed information from SouthWest Lincolnshire Clinical Commissioning Group (CCG), NHS England (NHSE), Public Health England (PHE), Healthwatch and NHS Choices.

We carried out an announced inspection on 4 February 2015.

We asked the practice to place a box and comment cards in reception to enable patients and members of the public to share their views and experiences of the practice with us.

During the inspection we spoke with eight patients. Patients told us they felt the service had improved over the last year although some dissatisfaction remained with the appointment system particularly with getting through to the practice by phone. Patients felt staff were helpful and caring. They were happy with the treatment and explanations and were treated with respect.

We reviewed seven completed comment cards where patients had shared their views and experiences of the service.

During our inspection we also spoke with members of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We spoke with 11 members of staff which included GP's, nurse practitioners, a nurse, the practice manager, the reception manager, the dispensary manager, a dispenser, receptionists and administration staff.

We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Good

Are services safe?

Our findings

Safe track record

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. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. They were able to give clear examples of incidents that had been reported and the process for dealing with them.

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

Learning and improvement from safety incidents

The practice had a robust system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last year. Significant events were regularly discussed at practice meetings. There was clear evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used specific incident forms and gave completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example we reviewed a significant event relating to a child with suspected meningitis who had attended the minor illness clinic. We saw that after the incident had been reviewed and discussed with the practice team, part of the process for at reception had been changed and this included isolating patient's who presented with a rash. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

The practice had a robust system in place to deal with national patient safety alerts. We saw that a record of each alert was kept in a folder and details of actions required were documented and each team member signed to say they had read them. We saw examples of actions taken in relation to alerts and staff told us that these were discussed at the next clinical meeting and the clinician responsible confirmed that necessary actions had been implemented.

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 regular 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 hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. We saw evidence of detailed documentation by clinicians of relevant consultations regarding safeguarding. Staff we spoke with were able to give us recent examples of safeguarding concerns they had raised and the process they had followed.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example we saw that if a child was on the protection register a pop up appeared on the patient record. We were told that the health visitor was in the practice every fortnight and would speak with the safeguarding lead and discuss any new concerns. The GPs could also see the health visitor on a drop in basis on a case by case basis if required.

The practice had a 'communications board' situated out of sight of patients in the reception area. This was regularly

updated and held various information but included details of current vulnerable patients to ensure practice staff were aware. This board was also used by the health visitor and district nurse.

The practice held monthly safeguarding meetings and one of the nurse practitioners was the dedicated lead for learning disabilities.

There was a chaperone policy and information available in the waiting room and consulting rooms which advised patients they could request a chaperone if they wished. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, a number of receptionists had also undertaken training and understood their responsibilities when acting as chaperones. We saw records which demonstrated that the practice manager carried out audits on the use of chaperones.

Medicines management

The practice had a lead for medicines management.

The dispensary had documents which they referred to as Standard Operating Procedures (SOPs). All staff involved in the procedure had signed the SOPs to say they have read and understood them and agreed to act in accordance with its requirements.

Standard Operating Procedures (SOPs) cover all aspects of work undertaken in the dispensary and consist of step-by-step information on how to execute a task and indicate the level of competency required for the task.

We found that the SOP's did not indicate the level of competency expected for each function performed by dispensers. The SOPs had been reviewed and updated in the last 12 months.

Records showed that all members of staff involved in the dispensing process had received appropriate training and there were records to demonstrate that their competence was checked regularly. We spoke with dispensary staff some of whom were not aware that competence had been checked formally since obtaining their qualifications.

The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

The dispensary accepted back unwanted medicines from patients. NHS England's Area Team made arrangements for a waste contractor to collect the medicines from the dispensary at regular intervals. We found that the dispensary had secure containers to keep the unwanted medicines in but there was no records kept of the medicines received by the practice. The practice had an identified locked area of segregation for the containers when they were full which is a requirement under the Hazardous Waste Regulations.

The practice held stocks of controlled drugs (medicines that require 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.

The practice provided a medicines delivery service one day a week for patients registered with the practice. They also delivered urgent medicines on other days when required.

We checked the medicine refrigerator in the dispensary and found medicines were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

The practice had robust arrangements in place to ensure that the cold chain was maintained for the delivery and storage of vaccines. Some members of staff had been trained to receive deliveries of vaccines and were aware of the importance of good vaccine management.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of the directions and evidence that the nurses had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

Good

Are services safe?

The practice held a 'shared care' folder of those patients who were on high risk medications. Each 'risk' medication had a list of those patients in the practice on the drug and the protocol relevant to that drug in the same section so it could be easily accessed. Secondary care providers planned and implemented the required monitoring including bloods but patients came to practice for blood to be taken. We saw that the results went back to the hospital but could also be accessed by the practice to avoid duplication.

Blank prescription pads were held securely in a key coded safe in the practice and there was a system in place for logging them in and out. However we found that a regular audit was not carried out to ensure the prescription pads were tracked. We spoke with the management team on the day of inspection who advised us they would put a process in place to ensure they adhered to national guidance.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed staff told us they would be returned to the GP for signature.

There had been one significant event for medicine errors which had been investigated in line with the practice policy.

Cleanliness and 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 always found the practice clean and had no concerns about cleanliness.

The senior practice nurse was the lead for infection control and 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 and annual updates. We saw evidence of the infection control audit that the lead had carried out in September 2014 and that actions had been identified. Minutes of practice meetings showed that 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 measures to control infection. 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 to comply with the practice's infection control policy. There was also a policy for needle stick injury.

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.

We checked two sharps bins in the dispensary. We found that the sharps bins were not correctly labelled and were over three quarters full. The Health and Social Care Act 2008 advises in the 'Code of Practice on the prevention and control of infection' all information requested on the Sharps box label must be completed in full. No Sharps box must be filled beyond the manufacturers maximum fill line indicated on each box

The practice had a policy for the management, testing and investigation of legionella (a bacterium that 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

Staff we spoke with told us they had 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, for example, the electrocardiogram machine (ECG) An ECG records the electrical activity of the heart.

Staffing and recruitment

We looked at five staff files and saw 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 policy that set out the standards 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. We saw there was a rota system in

place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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 keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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. Identified risks were assessed and rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was 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. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive. Hypoglycaemia is below normal blood sugar levels**.** Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

It was the policy of the practice not to carry any emergency medicines in the doctor's bag. A GP told us the practice assessed each home visit request by telephone before they visited, to ascertain if they needed to take any drugs with them and which ones. They would then take the appropriate drugs as required. The practice did not have a risk assessment to assess and mitigate the risks. We spoke with the management team and they told us they would look to review this arrangement after our inspection.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk had been comprehensively risk assessed and was rated and mitigating actions were recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

We were told and we saw evidence that the practice carried out weekly fire alarm tests and had carried out a fire risk assessment that included actions required to maintain fire safety. Emergency lighting was tested on a monthly basis. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 and from local commissioners. The nurses we spoke with told us that NICE guidance was discussed every two months at the clinical meeting. The last guidance spoken about related to hormone replacement therapy (HRT) and the menopause.

We saw evidence of numerous clinical protocols which could be accessed during consultations via the practice computer system. For example relating to epilepsy, insulin and chronic heart disease. We looked in more depth at the diabetes protocol and found it to be well researched and in line with local and NICE guidelines. This demonstrated that these actions were designed to ensure that each patient received support to achieve the best health outcome for them and that the GPs and nurses 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 but told us their area of responsibility changed annually. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines. Our review of meeting minutes confirmed that this happened.

We saw evidence of care plans which had been compiled for different groups of patients such as those with chronic obstructive pulmonary disease (COPD), those who were in care homes or those with complex needs who the practice considered would benefit from having a care plan in place. These were regularly updated personalised care plans which were printed out and kept in a file at the practice. The information in the plans was also kept on the practice computer system and a copy of the plan was left with the patient. We saw records of discharge summaries and the practice manager told us the process the practice used to review patients recently discharged from hospital, which involved administration staff contacting patients to see if they wanted an appointment with the GP.

We saw examples of referrals which were clinically relevant and used national standards for referral. Examples of referrals seen were clinically relevant and we saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

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. This information was then used to support the practice to carry out clinical audits.

The practice showed us 16 clinical audits that had been undertaken in the last year. Some of these were re- audits which completed the audit cycle. They included audits relating to glyceryl trinitrate (GTN) prescribing, D- Dimer testing in suspected pulmonary thromboembolism, a urine sample audit, a controlled drug audit, and an audit of atrial fibrillation patients not treated with anticoagulation.

We saw that a list of clinically relevant new audits had been planned for 2015 which included ensuring repeat prescriptions were generated within 48 hours, a sore throat audit and an audit related to avoiding admissions to hospital. Planned repeat audits were also listed.

The GPs told us 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 national performance measurement tool.

We looked in detail at an audit of prescribing of the combined oral contraceptive pill (COCP) in patients over 35 years of age. This was to determine whether prescribing was in line with United Kingdom medical eligibility criteria (UKMEC) levels of restriction for use from guidance published in 2009. The first audit identified a number of women who were at risk from their COCP due to risk factors of weight or smoking. These women were identified,

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Are services effective?

(for example, treatment is effective)

recalled and asked to consider their contraception choice. When the audit was repeated, no women over the age of 35 were considered to be at risk when the UKMEC guidance was applied.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets and in 2013/14 had performed higher than the practice average across England with a practice value of 98.4 compared to the national average of 96.4. The results showed there was a little room for improvement regarding chronic heart disease in some areas.

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. We saw that the practice computer system flagged up relevant medicines alerts when the GP was prescribing medicines.

We saw that the GPs issued weekly prescriptions for many mental health patients in order to avoid medication being stockpiled. Telephone consultations were sometimes used to carry out medication reviews with patients. We were told an exception to this was for antidepressant prescribing which was done face to face in order to monitor non verbal indications.

The practice had a palliative care register and we reviewed a folder relating to patients receiving multi disciplinary care. We saw there were regular monthly updates, however information was limited and sometimes consisted of only a patient diagnosis. The practice did however have a communication board in the practice which was used to alert the team to terminally ill patients as well as families needing support.

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 surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. Many of the practice's clinical domain results in QOF were higher than the CCG average.

Effective staffing

Practice staffing included medical, 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. We noted a good skill mix among the doctors and nurse practitioners. The practice employed two nurse practitioners who had additional expertise in women's health and respiratory medicine. Both nurse practitioners kept up to date with their professional development and attended updates and training as required.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Nurse practitioners and 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, cervical cytology. Those with extended roles ,for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

There was a system in place for staff to pass on, read and act on any issues arising from communications with other

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(for example, treatment is effective)

care providers on the day they were received. Post and non electronic test results were scanned and sent to the relevant GP. Electronic results went direct to the clinician concerned. There was a buddy system in place so that all incoming results were cleared on a daily basis. All staff we spoke with understood their roles and felt the system in place was well organised and worked well.

The practice were actively engaged with the Neighbourhood Team. This was introduced in 2014 in the CCG area and was designed to provide integrated care by bringing together health and social care professionals including GPs, community nurses, social workers, community psychiatric nurses and therapists. The aim was to join up the care provided to older people and those with some long-term conditions in order to enable those with complex needs to lead healthier, fulfilling and independent lives.

As well as attending neighbourhood team meetings and discussing the needs of complex patients the practice also held regular multidisciplinary team meetings to discuss the needs of other complex patients, such as those with end of life care needs.

Information sharing

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Incoming information could be scanned and kept on patient's records within this system.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it.

The clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. The practice had recently introduced a 'birthday pack' for 16 year olds. This meant patients who turned 16 were sent a pack which contained forms to consent to contact by SMS (mobile telephone texting), to allow parental involvement in their care and a form to complete if they wanted to opt out of having a shared care record. The purpose of this was to treat them as individuals and acknowledge their rights to make choices.

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. The practice had a higher than average number of patients with a learning disability. One of the practice nurses was the lead for learning disabilities.

Health promotion and prevention

The practice offered NHS Health Checks to eligible patients aged 40-74. Staff told us that if any risk factors were identified nursing staff could speak with a GP immediately and put a note on the computer system to identify concerns and to ensure the patient was seen by the GP.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. We saw an example of this relating to atrial fibrillation.

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 all patients with a learning disability and they were offered an annual physical health check. The practice offered in house smoking cessation clinics to patients. There were similar mechanisms of identifying 'at risk' groups which were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Practice nurses who saw patients for review of a long term condition worked closely with the GPs and would ask a GP to see a patient there and then if there were immediate

Good

Are services effective?

(for example, treatment is effective)

concerns. If a GP was not available there was a system in place to 'tag' the patient who would stay on the system until the GP had contacted them which meant the onus was not on the patient to make an appointment.

The practice's performance for cervical smear uptake was 75% which was slightly lower than the national and CCG average. The practice had a system in place to follow up non attenders for cervical screening and reviews.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

From our discussion with the senior GP we found that for patients with poor mental health the GP often booked a follow up appointment themselves to help reduce patient distress and were able to offer flexible appointments. The senior GP told us that they ensured that they referred patients directly to the community mental health team rather than relying on self referral from the patient. Following this the community psychiatric nurse would make contact with the patient within two weeks.

The practice had two dementia 'friends' attached to practice. Dementia friends have undertaken learning about what it is like to live with dementia in order to gain a greater understanding and enable them to offer support to those with dementia.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 118 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied on the whole with how they were treated and that this was with compassion, dignity and respect. The results from the national patient survey showed that 85% of practice respondents saying they had confidence and trust in the last GP they saw. The practice's own survey showed that 98% of patients felt they were treated with care and concern by GPs and nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were caring, respectful and efficient.. We also spoke with eight patients on the day of our inspection. All told us they were generally 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 and 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 switchboard was located away from the reception desk which helped keep patient information private. There was also a side room receptionists could use if patients wanted to speak more privately

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

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 75% of practice respondents said the GP involved them in care decisions and 73% felt the nurse GP involved them in care decisions. These results were lower than the average for the CCG. The results from the practice's own satisfaction survey showed that 94% of patients were satisfied with their level of involvement in making decisions about their care.

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. The feedback on six out of seven of the comments cards we received was also positive and aligned with these views. However one patient felt they were not sufficiently involved in their child's care.

We saw evidence that the practice had put in place detailed care plans for patients when it was considered beneficial and these were made in agreement with the patient. A copy of the plan was left at the patient's home to keep them up to date and involved with their care plan.

Patient/carer support to cope emotionally with care and treatment

Information available in the patient waiting room and on the practice website also told people how to access a number of support groups and organisations. The practice had a carers policy and 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 they were kept informed by the practice manager of families who had suffered a bereavement. The practice manager sent a sympathy card on behalf of the practice following a bereavement and staff were also able to give information and advice on how to find a support service. There was information on display in the waiting room relating to meetings of a local bereavement group.

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 recognised and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example they were in the process of implementing a new appointment system in response to concerns raised through the most recent practice survey.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had a relatively high number of patients with a learning disability and had appointed a lead nurse to focus on the needs of this patient group and to give continuity to their care. The lead nurse worked closely with the health liaison nurse for learning disabilities.

The practice had access to online and telephone translation services and their website could be translated into a number of different languages.

We saw that staff attended training days and as part of this received training on equality and diversity.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated in a single storey building which meant all patient services were on one level. The practice was spacious and had wide corridors which made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The majority of the practice population were English speaking though they could cater for other languages through translation services.

Access to the service

The practice was open from 8.00am to 6.30pm. Appointments were available from 8.30am to 6.30pm on weekdays and until 8.00pm on alternate Tuesdays and Thursdays which was useful to patients with work commitments. The practice also operated a nurse practitioner led minor ailment clinic between 8:30am and 10:30am on weekdays. Emergency same day appointments were available which were triaged by the duty GP. Telephone appointments were also available. Appointment booking and repeat prescription ordering were available online.

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 to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits which included visits to local care homes were made on a daily basis. The visits were shared between the GP's and the nurse practitioners.

Not all patients were satisfied with the appointments system. The most recent results from the national GP patient survey which related to 2013 – 2014 showed that the proportion of respondents survey who stated that they always or almost always saw or speak to the GP they preferred was only 9% compared to the national average of 37%. Three out of the eight patients we spoke to on the day of our inspection said it was difficult to get through on the

Good

Are services responsive to people's needs?

(for example, to feedback?)

phone to make an appointment and chose to come in to the practice to make an appointment instead. One person out of the seven who completed a comment card shared this view.

However the practice was in the process of changing the appointment system. This was in response to patient dissatisfaction which had been expressed through the PPG or the patient survey. In November 2014 they had introduced a nurse practitioner led minor ailment clinic between 8.30am and 10.30am and we were told this was becoming more popular as patient awareness of it grew. Two of the comment cards we received described the minor ailment clinic as an excellent facility. The majority of patients we spoke to felt that the appointment system had improved over the last year. The practice told us that on the week of our inspection they were introducing appointments between 3.00pm and 4.00pm with the aim of fitting in with school hours for children. They were also considering other options to improve access to appointments.

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. The practice manager was the lead for complaints handling in the practice.

We saw that information was available to help patients understand the complaints system. There was information available about the complaints process in the waiting room and on the practice website and this included information about advocacy support to raise a complaint and the Patient Advice and Liaison Service. Patients we spoke with told us they were not aware of the process to follow if they wished to make a complaint but only because they had never had to make one.

We looked at four complaints received in the last 12 months and found these were fully investigated, dealt with in a timely way and the practice had shown openness and transparency when dealing with complaints.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. Staff we spoke with told us complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. We saw evidence that the monthly practice meetings included complaints as a standing item on the agenda.

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 vision and practice values were part of the practice's statement of purpose which was available on the practice website. The vision and values included aiming to provide personalised, effective and high quality General Practice services, committed to the health needs of all patients and working in partnership with patients, their families and carers, involving them in decision making about their treatment and care.

We spoke with eleven members of staff who demonstrated that they were working towards the practice's vision and values and knew what their responsibilities were in relation to these.

At the time of our inspection the practice were aware that they needed to review staffing levels going forward due to a GP planning to leave the practice and had started to put plans in place to address this.

The GP told us that they planned to carry on streamlining care where possible, as they felt that, for example, the introduction of online appointment booking had been a positive step.

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 15 of these policies and procedures. All the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP was the lead for safeguarding. We spoke with eleven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued and knew who to go to in the practice with any concerns. The clinical care was very well supported by diligent non clinical staff.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at team meetings and systems were in place to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw a list of proposed audits for 2015. We also saw an audit which had been carried out on record keeping 2015 for each GP which demonstrated consultation monitoring by the practice. This showed good levels of reporting as to clinical symptoms, signs, investigations and treatment in the computer notes. The practice planned to re-audit this area in the future to ensure standards were kept up.

The practice had arrangements in place for identifying, recording and managing risks. We saw that risks had been discussed at practice meetings. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings. Staff we spoke with said the practice was well led and described the working environment as being one based on trust, mutual respect and good team working. They felt the practice manager was well organised, professional and always willing to help and support. The GPs were considered to be friendly and approachable by the staff we spoke with.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example relating to disciplinary procedures and leave which were in place to support staff. We were shown the employee handbook that was available to all staff, which included sections on flexible working and harassment at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, the NHS Friends and Family test and

Are services well-led?

Good

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

complaints received. We looked at the results of the annual patient survey and saw that there was some dissatisfaction with the appointment system. We saw as a result of this the practice had introduced a new appointment system.

The practice had an active and well established patient participation group (PPG) which has steadily increased in size. The PPG had been helpful in determining patient demand particularly relating to appointment provision. The practice had started to rework the appointment system recently following dissatisfaction voiced by patients regarding access. The PPG had been involved in producing practice surveys and met every quarter. The practice manager showed us the analysis of the last patient survey and the related action plan which had been compiled in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and day to day discussions. Staff told us they felt comfortable and encouraged to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around ear syringing and this had happened. 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 five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice encouraged and was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared learning with staff to ensure the practice improved outcomes for patients.