South Molton Health Centre

Quality Report

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Date of inspection visit: 4 November 2014
Date of publication: This is auto-populated when the report is published

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

South Molton Health Centre was inspected on Tuesday 4 November 2014. This was a comprehensive inspection.

This practice provides primary medical services to people living in the North Devon town of South Molton and the surrounding areas. It provides services to a diverse population age group and is situated in the heart of the town.

Five GP partners and a retained GP make up full time equivalent of 3.65 GPs which provides cover for approximately 5,500 registered patients. A mix of services is provided in addition to core services, including carers' health checks. Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

We found this practice promoted safe working practices energetically and systematically and was very responsive to patients' needs. We found the practice was effective, caring and well led.

Our key findings were as follows:

Patients told us they had found staff to be helpful, kind, caring and patient. Four patients said their care had been excellent. Patients told us that their GP listened to their problems, explained treatment options so they could understand and treated them with dignity and respect.

Patients said that this service had not made assumptions about people, or 'pigeon-holed' them. They said the GPs and staff would expand a service in order to fit a person in, if necessary. There were systems in place, but variations could be made for individual's welfare. Patients said the positive relationships observed within the team gave them confidence and made them feel comfortable.

A duty system had been introduced. There was a GP each day to deal with urgent appointments during normal opening hours. There were also some same day non-urgent slots available. Patients told us it was a good system and that staff were prepared to flex it to accommodate a patient.

Nurses ran clinics for patients with coronary heart disease, asthma, chronic obstructive pulmonary disease

Summary of findings

(COPD)**,** hypertension and diabetes. This recognised the needs of the locality. They followed up blood test results and any patients who did not attend to ensure they received essential treatment.

Infection prevention and control (IPC) was actively monitored throughout the practice. Progress was checked at monthly intervals at the Quality Group meeting. Achievement was recorded every month, with a different aspect of IPC promoted across the practice.

Good communication was maintained to provide good outcomes for patients. Practice nurses told us they were in regular communication with district nurses about the patients that they both treated.

The management team had developed a set of core competencies to outline expected standards of behaviour across the whole practice, for partners and staff. There was a clear leadership structure with named members of staff in lead roles and all the staff who spoke with us were clear about their own roles and responsibilities.

We saw outstanding practice including:

There was a reliable and proactive method for maintaining safe working practice. The Quality Group met bi-monthly to monitor progress and included a GP partner, a staff representative, the practice manager, deputy practice manager and lead nurse. All matters to do with any aspect of patient safety identified by any staff member were entered on the risk register, which was seen to be a working document. Each meeting, new concerns and progress with old ones were discussed, focussing on items that team leaders were actively promoting. The spreadsheet was updated each month and the current version made available for staff input over the next month. This provided a reliable and proactive way of assessing risk and taking action effectively across the whole practice to provide a safe service.

The practice joined in an annual outreach event in town hall with local voluntary groups providing health promotion, lifestyle advice and health checks. This year the event was entitled 'Ageing Well'. The practice took care to offer flexibility with appointments to enable people who could not drive, to access services, where public transport was limited to one bus per week. Staff arranged for prescriptions to be signed on the day to avoid the need for a repeat journey.

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.

The Quality Group met bi-monthly to monitor progress and included a GP partner, a staff representative, the practice manager, deputy practice manager and lead nurse. All matters to do with any aspect of patient safety identified by any staff member were entered on the risk register, which was seen to be a working document. Each meeting, new concerns and progress with old ones were discussed, focussing on items that team leaders were actively promoting. The spreadsheet was updated each month and the current version made available for staff input over the next month. This provided a reliable and proactive way of assessing risk and taking action effectively across the whole practice to provide a safe service.

The lead nurse introduced a different aspect of good practice in infection control across the practice each month. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement.

Are services effective?

Good

The practice is rated as good for providing effective services.

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.

GPs told us of update courses they attended annually which provided a handbook and DVD containing summary distillation of the latest medical evidence for GPs. A GP cascaded the various learning points to colleagues and discussed pertinent elements with them.

The practice had a system in place for completing clinical audit cycles. For example, an audit was undertaken into the use of anti-psychotic medications in patients with a diagnostic code of dementia. This was to provide assurance that the medications were only given for the recommended duration before review and that

Summary of findings

they were prescribed appropriately. The practice compared their prescribing and referral rates to other local practices and if higher than expected had undertaken a retrospective audit of that area. The practice had a central repository for audits undertaken.

GPs in practice undertook peer to peer review of referrals which they found to be honest, good natured and non-threatening.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients told us they had found staff to be helpful, kind, caring and patient. Four patients said their care had been excellent. Patients told us that their GP listened to their problems, explained treatment options so they could understand and treated them with dignity and respect. Patients we spoke to in the course of this inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received

Patients said that GPs and staff would expand a service in order to fit a person in, if necessary. There were systems in place, but variations could be made for individual's welfare. Patients said the positive relationships observed within the team gave them confidence and made them feel comfortable. We observed staff treating patients with respect and taking care to preserve their dignity.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had introduced a system of telephone triage by GPs for all appointment requests. Patients did not like this, so it was discontinued, showing how responsive the practice was. A duty system had been introduced. There was a GP each day to deal with urgent appointments during normal opening hours. There were also some same day non-urgent slots available. Patients told us it was a good system and that staff were prepared to be flexible to accommodate a patient.

Staff told us that when patients failed to attend for their appointment, they followed up to find the reason. Nurses told us they were in regular communication with district nurses about the patients that they both treated.

Nurses told us they found the service was flexible for patients, and they could give them the time they needed, and not be confined to 10 minutes. They found their patients liked this. This showed how the service was responsive to patients' needs.

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The timing of appointments took into account bus availability. For example, buses came from some villages only on market day. The practice accommodated this requirement for rural patients although it put pressure on the staff.

The practice manager had gone to a local college to give a presentation about Summary Care Records to ensure that people not normally engaged with the practice understood the issues and their rights with respect to confidentiality and opting out. These are electronic records stored at a central location, accessible to health care staff by the use of a smart card should the patient need care when their GP practice is closed.

Are services well-led?

Good

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

South Molton Health Centre's stated aims were to provide high quality medical care in a safe and friendly environment which is accessible to all. GPs and nurses were working in accordance with this vision, stating their expectation was to provide flexible care focussed on patients' needs. Patients confirmed this was their experience.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a prescribing lead, one GP was the lead for safeguarding vulnerable adults while another was lead for child protection. All the staff who spoke with us were 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.

The members of the patient participation group known as P3 who spoke with us were pleased with the progress of their group and agreed it was working very well. They told us they found the practice really did listen to them and tried to put their requests into practice.

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

Outstanding ☆

This practice is rated as outstanding for the care of older people.

The practice took care to offer flexibility with appointments to enable people who could not drive to access services, where public transport was limited to one bus per week. Staff arranged for prescriptions to be signed on the day to avoid the need for a repeat journey.

The building had been made accessible with a power assisted door and wheelchair access to most areas. Raised chairs had been provided in the waiting room for the use of patient with reduced mobility and three of the treatment rooms had been furnished with adjustable height couches. Staff were prepared to help frailer patients by ringing a taxi for them and helping them to and from the consulting rooms.

The practice joined in an annual outreach event in town hall with local voluntary groups providing health promotion, lifestyle advice and health checks. This year the event was entitled 'Ageing Well'.

GPs had built good relationships with local care homes. They had been proactive about raising any concerns over care and trying to work with the homes to improve their procedures and ability to provide good patient care.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions.

The full range of chronic disease clinics were provided - coronary heart disease (CHD), diabetes, asthma, chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD) and hypertension. There was a recall service to ensure patients received the checks they needed. Patients were offered regular testing if they were prescribed anticoagulant medicines and they had the option to attend in the practice or a separate phlebotomy service for their blood tests.

They gathered feedback from patients with long term conditions who served on the patient participation group known as P3.

Summary of findings

The practice offered active carers support, led by a member of the administrative team who developed a link with the carer who was then offered health and well-being checks with follow up. A specific notice board was provided in the waiting room to display information about carers' issues.

A same day consultation was always available if needed. A 'named usual doctor' service had been in place for a long time to give good continuity and personalised service. Patients with complex needs had their care proactively managed on 'virtual ward' in collaboration with other health care professionals to make sure their changing needs were identified and met.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people.

A full child health programme was offered with vaccinations in accordance with national guidelines. The practice aimed to achieve a baby's eight week check on the same day as the post natal check and the first immunisations, for the convenience of the new parent. Nappy changing facilities had been provided and a side room was provided so that mothers could breast feed in private. Staff were prepared to childmind whilst a parent was in with a health care professional.

The practice had made efforts to maintain good communication with midwives and health visitors who no longer shared the same site.

They had built up good relationships with the local community college and established a link with the school council. Some young mothers had been recruited on to the patient participation group known as P3 who were therefore able to give regular feedback to the practice.

Working age people (including those recently retired and students)

Good

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

The practice had made arrangements flexible so that patient could book appointments at their own convenience. Patients could book appointments and reorder repeat prescriptions via the practice's website. Evening and lunch time surgeries were available so patients could avoid using their working hours, and telephone consultations were available daily.

Summary of findings

NHS health checks were offered for patients over the age of 40. The practice manager was currently working on a project with CCG and the local hospital trust to improve access to physiotherapy services.

A full travel health service was offered, including yellow fever.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people whose circumstances may make them vulnerable.

Medical assessment and treatment was provided immediately when needed for people who were homeless, travellers, or itinerant workers. Patients who had been victims of physical abuse including domestic abuse were supported and signposted to other services. Patient alerts were entered on the computer to help staff identify people in these situations in order to make an appropriate response to support them.

Vulnerable adults and children known to the practice were discussed at the regular multidisciplinary team meeting, in order to co-ordinate care and keep colleagues up to date with any changes in patients' well-being. There were effective arrangements in place to support anyone needing to raise an alert.

A GP took the lead on learning disability for the practice. They had developed their working relationship with a local residential care home for people with learning disabilities, visiting regularly so that patients would be familiar when they needed examination or treatment, and to provide support to the staff.

Staff were aware of patients for whom English was not their first language. They said they had access to a translation service if required but that most patients came with their own translator.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The CPN for the elderly attended the practice's multidisciplinary team meeting to contribute to care planning. GPs carried out advance care planning for patients with dementia.

Summary of findings

Longer appointment times were regularly given for a mental health consultation. Patients' blood pressure and body mass index (BMI) were checked before their annual reviews. Nurses were alert to the possibility of low mood, particularly with new mothers, to help with identification of developing problems.

Patients were signposted to depression and anxiety services. They were encouraged to self-refer.

A private counsellor visited the practice, providing a choice for patients. An Alzheimers Disease society support worker was linked to the practice.

The practice manager had regular meetings with community psychiatric nurses (CPN) to ensure good collaboration. The CPN saw patients in the practice when that was more helpful than seeing them in their home.

Summary of findings

What people who use the service say

We spoke with people who used the service including two members of the patient participation group, called P3, who came in to meet us. Fourteen patients used our comment cards to give feedback, and we heard from five other patients by phone or email.

Patients told us they had found staff to be helpful, kind, caring and patient. Four patients said their care had been excellent. Patients told us that their GP listened to their problems, explained treatment options so they could understand and treated them with dignity and respect.

Patients said that this service had not made assumptions about people, or 'pigeon-holed' them. They said the GPs and staff would expand a service in order to fit a person in, if necessary. There were systems in place, but variations could be made for individual's welfare. Patients said the positive relationships observed within the team gave them confidence and made them feel comfortable.

Some patients said they appreciated the late opening hours. No-one complained of difficulty getting an appointment. One person said the practice worked like clockwork with nothing but proficient GPs. Another told how three generations of their family had been coming to this practice, had always received excellent service and been treated with great understanding.

Some patients gave tribute to their GP for giving information and explaining their health care needs. They appreciated that if there were any discrepancy with regular blood tests their GP phoned to discuss, and did not leave it for another GP to call.

Members of P3 told us the practice manager was very conscientious about working with patients and getting feedback from them. They asked her to chair the two monthly meetings. A GP always attended as well, they took turns so that all GPs had a connection with the group. Other team leaders sometimes attended.

The group were considering ways of widening the group of patients from whom they received feedback. Some patients kept in contact with the group by email but were unable to attend meetings. The members who spoke with us were pleased with their progress and agreed it was working very well. They told us they found the practice really did listen to them and tried to put their requests into practice. They gave the changes in the appointment system as an example. The practice had changed the appointment system, introducing a GP triage phone call. Patients did not like it, so they changed it again. They introduced closing the phone line over lunch time and putting on the answer phone. Patients did not like it, so they stopped. They thought it very helpful that patients could phone the practice and speak to a GP. They appreciated that the practice would make small adjustments to make systems work for individuals.

Outstanding practice

There was a reliable and proactive method for maintaining safe working practice. The Quality Group met bi-monthly to monitor progress and included a GP partner, a staff representative, the practice manager, deputy practice manager and lead nurse. All matters to do with any aspect of patient safety identified by any staff member were entered on the risk register, which was seen to be a working document. Each meeting, new concerns and progress with old ones were discussed, focussing on items that team leaders were actively promoting. The spreadsheet was updated each month and the current version made available for staff input over the next month. This provided a reliable and proactive way of assessing risk and taking action effectively across the whole practice to provide a safe service.

The practice joined in an annual outreach event in town hall with local voluntary groups providing health promotion, lifestyle advice and health checks. This year the event was entitled 'Ageing Well'. The practice took care to offer flexibility with appointments to enable

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people who could not drive, to access services, where public transport was limited to one bus per week. Staff arranged for prescriptions to be signed on the day to avoid the need for a repeat journey.

South Molton Health Centre

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 and a practice manager.

Background to South Molton Health Centre

South Molton Health Centre is a town centre practice, based at 9 –10 East Street,

South Molton, Devon EX36 3BZ. Around 5,500 patients are registered with the practice.

There are five GP partners, three men and two women and a retained GP(female). Three qualified nurses are employed, plus two health care assistants.

A large proportion of registered patients are older people, so there is a high level of need with respect to long term conditions and complex needs. The population is quite stable and includes young families and working people.

This is a training practice, with medical students, a registrar and a trainee doctor in the second year of their foundation programme.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, counsellors and midwives.

This practice was last inspected in January 2014 when it was found to be compliant with the outcome groups that were inspected.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Out of practice hours, patients are directed to NHS 111.

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 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.

This provider had not been inspected under the new method of inspection and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 November 2014.

During our visit we spoke with a range of health care professionals and administrative staff and spoke with

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patients who used the service including members of the patient participation group (P3). We phoned patients, with their consent, after the visit and also talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had a reliable and proactive way of assessing risk and taking action effectively across the whole practice. The Quality Group met monthly to monitor progress and included a GP partner, the practice manager, deputy practice manager and lead nurse. All matters to do with any aspect of patient safety identified by any staff member were entered on the risk register, which was seen to be a working document. Each month, new concerns and progress with old ones were discussed, focussing on items that team leaders were actively promoting. The spreadsheet was updated each month and the current version made available for staff input over the next month. Risks monitored included infection control issues and medicines safety. For example, during August 2014 staff identified that the water dispenser was not part of any cleaning schedule, while the record of the October meeting recorded that cleaning staff now had this included in their duties. Similarly, staff had been informed that blood pressure cuffs needed to be cleaned between use, and action by the end of the month following this inspection was for clinicians to clean cuffs between each use, using wipes provided for the purpose.

The practice used a range of information to identify risks and improve patient safety, for example, reported incidents and national patient safety alerts. The practice manager received the alerts and forwarded them to all health care professionals. When there was a particular clinical lead for the area of the alert, that GP could ask for further information, for instance about a medicine. They would then share this with the usual doctor for patients who were affected, for them to take action. For example, when an alert was issued in respect of potential harmful interaction between two commonly used cardiac drugs there were two potential options in either dose reduction or switching one of the drugs. The GPs met to discuss options and made a decision that was consistent throughout the practice.

A staff member took responsibility for COSHH assessments (control of substances hazardous to health).

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events.

The significant event record (SER) was well structured. It showed how events were assessed and reviewed by the appropriate person, action points were completed and learning was shared with the team. When an incident occurred, the GP to whom it was reported would carry out an initial investigation as appropriate but also inform the practice manager for an overview so that any emerging pattern could be identified. For example, a GP reviewed results of a test that had recorded the electrical activity of a patient's heart (ECG) and indicated on it that a patient review would be required. The item was mistakenly filed by a member reception staff without an appointment being made. This incident resulted in a change in practice so that all post or other documents requiring further action were dealt with through the office manager's desk.

Another example of a change in practice following a significant event analysis was the practice now follows up patients who failed to attend for an arranged test. This was extended to those patients who had yet to book their hospital appointment. This information was passed to the GP who could contact them inviting a further discussion if there could be consequences.

GPs confirmed that as a practice they looked at significant events to try and identify learning and make changes. A nurse confirmed that she saw minutes of SER meetings. She knew about recent accident in which a patient had suffered a fall in a treatment room and told us about learning that had been shared following that incident. Staff were confident in the way that safety was maintained in the practice and knew who to speak to about any suggestion for improvement they might wish to propose.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and vulnerable adults. The practice had gathered information from the Devon County Council multi-agency safeguarding team to recognise their responsibility for safeguarding vulnerable adults and protecting children. There was a lead GP for protecting children who was level three trained for child protection. All other GPs had achieved level three, or level two and were working towards level three. Another GP was lead for safeguarding adults. GPs had also undertaken training in safeguarding vulnerable adults which one GP described as fascinating and informative. One GP had attended lectures while in a previous post but not as part of

their current deanery. The practice manager kept a spreadsheet on the computer as a central matrix of training, but GP training in safeguarding was not recorded. GPs had been requested to provide evidence of their achievement. The risk register recorded this as an action to be completed by 30 November 2014 so we could be confident it would be followed up.

GPs and staff who spoke with us knew who was the safeguarding lead for adults and for children and knew who to speak to if they needed to raise a concern or an alert. One staff member told us how well they had felt supported within the practice when they had needed to raise an alert. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as health visitors and social services.

A nurse showed me how she could access all policies on the intranet including a suitable whistle blowing policy which gave staff guidance on how they could raise a concern about poor practice or abuse within the practice.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. Relevant certificates were in place to show that relevant staff had undertaken and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The files of nurses and administration staff contained good evidence of the recruitment procedure being followed. The files were well organised and documents were in place showing that the necessary checks had been made while recruiting staff to ensure where appropriate that staff were safe to work with vulnerable adults and children and had provided evidence of their qualifications.

The practice had a written policy and guidance for providing a chaperone for patients. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they felt one was required.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. There was a written procedure on what to do on the event of a break in the cold chain, including contacting the manufacturers. The vaccination fridge was hard wired which meant it could not be disconnected. An annual audit had been carried out which had identified the need for the thermometer to be calibrated. This was carried out and added to the list of checks.

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

Prescription pads were present in GP's bags with numbers recorded but were otherwise in stored in a locked cupboard. GPs were allowed three prescriptions for home visits which were audit trailed. Patients were at no time left alone in GP rooms and rooms containing printers and blank prescriptions are kept locked when not in use to ensure security of the prescribing process.

GPs did not carry controlled drugs but these were available to them from locked storage with counter signature process of sign out, in the event that they were needed for a visit to a patient's home. 'Just in case' boxes had been introduced locally. These had uniform contents and paperwork across the area, so that any deputising doctor attending a patient would be familiar with the drugs and charts being used. GPs had support with this prescribing from a hospice nurse who in turn had access to a palliative care consultant for guidance and support. One GP showed us conversion charts they carried so they could switch someone over from an oral form of morphine to alternatives if the patient's condition changed.

A GP took responsibility as prescribing lead for the practice. They monitored the use of broad spectrum antibiotics and the computer reminded GPs of this issue if they tried to prescribe one of these medicines, and suggested alternatives available.

The lead nurse checked the medicines monthly, and all those we saw were within their expiry date. There was an

appropriate storage facility for controlled drugs (CDs). The key was kept securely and a CD record was kept to ensure proper use of the medicines. The lead nurse, with a colleague, checked the whole building at six monthly intervals, looking in all cupboards including in GP consultation rooms to ensure no out of date products were on site.

Cleanliness and infection control

The lead nurse had a degree level module in infection prevention and control (IPC). She carried out an audit when she joined the practice. This was included in the risk register which means it has been monitored and updated at monthly intervals at the Quality Group meeting. We saw that progress was recorded every month, with a different aspect of IPC promoted across the practice. The practice manager described the lead nurse as a driver for change. She introduced new IPC strategy each month, sending an email to the whole team. For example, she identified an infection control risk with respect to hand hygiene and provided training in hand washing to all practice staff and GPs. Staff confirmed they had guidance such as emails telling of the new venture for the month, for example, clearing worktops of clutter.

We saw that safe procedures were in place for dealing with sample handling, use of personal protective equipment such as gloves and aprons,

It had been agreed that any building work must be considered in terms of IPC. Changes to the treatment rooms was planned with a sluice provided and a purpose built accessible toilet.

Waste was carefully managed with separate processes for domestic, clinical and hazardous waste. Sharps boxes were changed every three months or when they were three quarters full. Clinical waste consignment notes were all in place, demonstrating legal collection of all waste.

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. There was a policy giving staff guidance on checking resources. A schedule of testing was in place. For example, a HCA checked blood glucose monitors before each clinic and the suppliers came to carry out a three-monthly check to assure accuracy.

Equipment for dealing with medical emergencies was checked once a month by trained nurses. It was kept in a bag with a tamper tag, retagged each month and only the nurses had access to the tags. Oxygen cylinders, were turned on to check they were working and tubing attached, anaphylaxis kits were checked, the AED battery and pads expiry dates were checked. The nebuliser was checked daily to ensure it was ready for use.

The practice offered equipment for testing blood pressure for patients to take for home monitoring, 11 were on loan at the time of this visit, and more were available if required. This was in response to a high incidence of coronary heart disease, due to a high proportion of elderly people in the population. Self-testing kits for chlamydia were available and any staff could provide these to patients under the age of 25 years.

We saw evidence of calibration of relevant equipment performed on annual basis, last performed during February 2014. Portable electrical equipment was routinely tested and we saw that this was in date.

Staffing and recruitment

The practice had a suitable policy on recruitment of staff, which was carried out consistently for all types of staff. The practice manager kept central staff records in order to maintain an overview and support the smooth running of the practice. When locum GPs were employed, proactive checks were made to ensure they were suitable to work at the practice. The practice manager kept a central record of checks on all GPs whether locum, salaried, registrars or partners of their registration with the general medical council (GMC), their identity, Disclosure and Barring Service (DBS), indemnity and acceptance on the NHS performers' list. Clear records were kept of their appraisal dates, revalidation, or if they were recently qualified, of the date this would be needed.

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 staff representative for quality.

The practice kept a risk register which was checked and updated every month to record identified needs and make sure that action was taken to address them. For example, the October 2014 meeting recorded that recent advice from the Health and Safety Executive suggested that a full tank clean-out and regular temperature testing was appropriate to mitigate any risk of Legionella, and an action date of 30 November 2014 had been accepted.

Staff and management actively promoted safety in the workplace. For example, the fire safety policy had been reviewed in July 2013 and the fire risk assessment was due for review in 2015. The fire alarms had been serviced and checked and there was clear signage of fire escapes. A weekly fire alarm test was performed and recorded with good evidence of rotation testing and recording, including resolving issues. Training for staff in fire procedures was included in the induction process and an evacuation fire drill was performed annually. The last one took place on 24 March 2014 and the outcome was reviewed and recorded.

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). An alarm button was in place (under the desk) in treatment rooms and GP consultation rooms, and an alert could also be made through the computer system. Staff training included familiarisation with contents of the emergency pack which contained laminated instructions for emergencies. In a recent case of severe anaphylaxis the GP handling the case found this aide memoire very helpful in the stress of an emergency situation. 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.

The practice had a suitable business continuity plan which had been reviewed to make sure it would provide staff with guidance and included contact details for staff and suppliers that had been kept up to date.

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.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. A trainee GP as part of their programme had presented NICE guidance in respect of cancer referrals to all GPs. Staff were pleased to show us the dictation machines used by GPs to get their letters onto the computer and to the secretaries. Referrals to hospitals were made using the 'choose and book' system, signed by the GP on dispatch and sent on the same day if urgent or by the next day if routine. In the event of the patient's GP no longer being on duty, a 'buddy' GP would sign to avoid any delay. A patient told us that after a scan, which had been carried out efficiently, they had been referred to the local district hospital and received aftercare, with all the information they needed following smoothly.

A trainee GP told us that at their level of competence they needed a second opinion from a GP in order to make a suspected cancer referral. They had found this to be available without any delay and the referrals had been dictated immediately with the typed letter being available often within half an hour.

GPs told us of update courses they attended annually which provided a handbook and DVD containing summary distillation of the latest medical evidence for GPs. A GP cascaded the various learning points to colleagues and discussed pertinent elements with them. Those who attended the course received links to new evidence as it appeared. One GP had signed up for these and shared the links with colleagues. For example, the update had recently included new thinking on the cardiac investigation of chest pain. NICE update bulletins were passed to GPs by the practice manager.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a national performance measurement tool. GPs reported that this data had always shown they performed well and the GP's view was that QOF drove good patient care and they would continue the work regardless of financial incentive.

The practice had a system in place for completing clinical audit cycles. For example, an audit was undertaken into the use of anti-psychotic medications in patients with a diagnostic code of dementia to provide assurance that the medications were only given for the recommended duration before review and that the additional code for behaviour issue was present to indicate that there was an appropriate therapeutic indication. The practice compared their prescribing and referral rates to other local practices and if higher than expected, had undertaken a retrospective audit of that area. The practice had a central repository for audits undertaken which was helpful as staff knew where they could find them.

GPs within the practice undertook peer to peer review of referrals to hospital services. They told us they found this to be honest, good natured and non-threatening.

The GPs met with a local consultant psychogeriatrician and community psychiatric nurse (CPN) to discuss safe use of anti-psychotic drugs, following the audit just described, demonstrating how they used an audit to underpin improvements in practice.

Nurses ran clinics for patients with coronary heart disease, asthma, chronic obstructive pulmonary disease **(**COPD)**,** hypertension and diabetes. This recognised the needs of the locality. They followed up blood test results, and any patients who did not attend and kept a record so they had evidence of follow up. Flu vaccinations were being managed well to meet the needs of the population in line with demands of QOF.

Doctors in the practice undertook minor surgical procedures in line with their registration and NICE guidance. A minor surgery audit identified that on a significant proportion of patients the relevant surgical pack numbers were not recorded and similarly batch numbers and expiry dates for injectables might also be absent from

Good

Are services effective?

(for example, treatment is effective)

the record. The action following this audit was for the IT manager to develop a template to be completed at the time of the minor operation which would prompt the clinicians to record this data so safety and accountability were enhanced.

Effective staffing

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. At South Molton Health Centre, locum GPs' revalidation was clearly checked. For partners and salaried GPs there was no record of revalidation but the dates were recorded showing that it was being tracked by management for assurance of continuity of service.

No GPs were registered as having a special interest, but one had a diploma in dermatology, another had expertise in intrauterine contraceptive devices. GPs could cross refer in the practice if seeking additional expertise in these areas. GPs within the practice undertook minor surgery including injections, incision and excision of all specimens including sebaceous cyst to histology. No low grade skin cancer (BCC) work was undertaken by the practice.

The progress that had been made in achieving QOF standards showed that the nursing team was operating effectively and managing their workload well. Staff said they were well supported with training. Newly recruited staff had been provided with a suitable induction training and a good training matrix was in place showing the training needs across the practice were assessed and met.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, nurses were qualified in administration of vaccines, cervical cytology, and one nurse was trained to carry out bladder washouts and insert male catheters.

Those with extended roles were also able to demonstrate that they had appropriate training to fulfil these roles, for example the lead nurse had completed a degree module in diabetes care. She was working towards qualifying as a prescriber and was also working on a masters degree in order to qualify as a nurse practitioner. This showed that the practice was seeking to extend its services and flexibility. Cover for trained nurses was suitably provided by qualified staff who were familiar with the practice and the patients.

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.

A multi-disciplinary meeting was held on alternate Tuesday lunch times. All GPs present met with nurses, the practice manager and deputy, district nurse, hospice nurse and community mental health nurse for the elderly. On a monthly basis the health visitor and school nurse also attended. The Complex Care Team, which included the community matron and care coordinator from the social services, also attended for the monthly gold standard framework meetings which discussed the care of patients receiving end of life care and those who were risk of unplanned admission to hospital. We saw the minutes of the meeting of 21 October 2014 and saw that care of vulnerable families, children and adults were standard agenda items, as were patients receiving palliative care, patients with mental health problems, any safeguarding issues and patients who had died. The practice worked with local integrated care pathways such a Pathfinders team for provision of care as well as physiotherapy and occupational therapy assessments.

We were given examples of care that had resulted in avoidance of hospital admissions. One patient was suffering psychological difficulties after surgery, not eating and neglecting care of their own appearance. The GP made telephone contact with the rapid response team by telephone, followed up with a letter. Early provision of a morning carer visit prevented hospital admission.

GPs had an option of providing continuing care to their patients in up to three beds at the community hospital. The other beds were the responsibility of the NHS Trust and were supervised by a trust doctor. Urgent and emergency cover was provided by the practice as a shared arrangement with a neighbouring practice at times of the working day when that doctor was not at the hospital.

Good

Are services effective?

(for example, treatment is effective)

GPs contacted patients to discuss results of tests, or asked staff to phone and ask the patient to make an appointment or book a telephone call with the GP. In the absence of the patient's GP, an administrator reassigned this task to another GP to avoid delay. Reports from out of hours services were also reassigned to make sure they were seen by an appropriate health care professional. The lead nurse kept five telephone slots of two minutes each, for example, to give results of swabs or to discuss diabetic changes.

A leaflet was displayed giving information about an independent counselling service, that the practice hosted on a regular basis to give patients a choice of service.

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 (OOH) provider to enable patient data to be shared in a secure and timely manner. We saw an example of special patient notes that had been uploaded to the OOH computer system by the practice to assist an OOH deputizing GP with further management of a more complex case should the patient make contact.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent forms for minor surgery were available on the intranet.

A new policy had recently been introduced with respect to the Mental Capacity Act 2005. We saw a training schedule had been planned, showing this was being implemented across the whole team. GPs had discussed issues of capacity during a meeting they had with a local consultant psychogeriatrician and CPN on the subject of prescribing practice.

The GP partners had all completed the training and some had experience of decision making when the patient was assessed as not having capacity to give informed consent. An example was given of a young adult with mental and physical health problems who was refusing assessment and treatment for an orthopaedic problem. Using their experience, prior knowledge and ongoing GP/patient relationship, the GP was able to demonstrate to a multi-disciplinary meeting that in the immediate context of this limited issue the patient did have the capacity to make the decision regarding further opinion for themself. There was knowledge within the practice of how to contact an Independent Mental Capacity Advocate (IMCA), should the need arise.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse 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 their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. Children were measured in school at age five and again at age ten. The GPs told us they were improving their communication with school nurses in order to be alerted to instances of obesity in children.

There was a television screen showing local information, and several notice boards and leaflet racks. The information provided for patients was up to date and well organised to inform patients about services available to them.

The lead nurse had introduced themes for health promotion, with monthly presentations on a noticeboard in the waiting room. At the time of this visit the theme was flu and shingles vaccinations. One of the previous displays had been about smoking cessation. The theme for the following month was booked for presenting the carers' checks that were offered.

Other information displayed was seen to be neat and up to date including information about whooping cough and pregnant women; support for people with Parkinsons disease; eye health; MacMillan services and many others.

Self-help groups were advertised, for example a hearing loss group, and 'After caring' for bereaved carers. The lead nurse was promoting GP participation, for example to provide a room for local self-help groups such as a leg ulcer group. One notice board had a display of information for carers, to inform them of the health checks that were offered and of support groups in the area.

Good

Are services effective?

(for example, treatment is effective)

One GP told us of useful websites identified for providing information and support to patients with mental health problems and their carers. These had been brought to their attention by a psychiatrist who had visited the practice. The GP gave patients education leaflets as well as signposting them to these sites.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us they had found staff to be helpful, kind, caring and patient. Four patients said their care had been excellent. Patients told us that their GP listened to their problems, explained treatment options so they could understand and treated them with dignity and respect.

Patients said that this service had not made assumptions about people, or 'pigeon-holed' them. They said the GPs and staff would expand a service in order to fit a person in, if necessary. There were systems in place, but variations could be made for individual's welfare. Patients said the positive relationships observed within the team gave them confidence and made them feel comfortable.

We observed staff treating patients with respect and taking care to preserve their dignity. Some GPs talked about how they used patient clothes and disposable examination couch roll to maintain dignity. There were locks on the door of consultation rooms secured with a key rather than a bolt, as being better for patient reaction.

Notices were displayed describing the chaperone policy. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment.

Care planning and involvement in decisions about care and treatment

Patients we spoke to in the course of this inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. GPs told us the practice had identified a cohort of patients for whom care plans were appropriate. These had been completed, after the GP discussed their plan with the patient and gained consent to discuss this with other health care professionals. More than 2% of the more frail and ill patients now had a care plan. There was currently a focus on patients in this cohort who had been admitted to hospital recently or had contact with an out of hours (OOH) service. GPs considered their group of frail and unstable patients to identify whether they would benefit from having their health care needs discussed by the multidisciplinary meeting.

One GP personally undertook the physical health checks for all patients with a learning disability as they felt they knew the patients well and had an understanding of how to avoid or deal with challenging behaviour.

There was a procedure for gaining consent from patients prior to minor surgery and the fitting of contraceptive coils. A GP discussed coils with the patient and made the clinical decisions. On the day of the fitting, the patient completed the consent form, which was scanned into their patient record. GPs were confident about how to use the Fraser Guideline and to understand about patients' competence to make decisions while under the age of 16, in accordance with Gillick competency. Notes were available on desktop for staff to consult.

Patient/carer support to cope emotionally with care and treatment

Staff told us that if families had suffered a 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. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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.

GPs considered they worked in a cohesive team that was able to provide a friendly and flexible service. Patients confirmed this, saying the receptionists were good at defusing tense situations, were understanding, polite and friendly. They said the staff were caring and the systems were used flexibly.

Staff told us that when patients failed to attend for their appointment, they followed up to find the reason for example, if the patient was elderly they may forget. If a patient regularly taking anticoagulant medicines failed to attend for their blood test, the nurse phoned them to check for problems. Staff were familiar with busy patients who were diabetic, and often needed reminding of regular checks to maintain their good health. Nurses' experience showed that patients coming for help to stop smoking often missed the first appointment but would later be regular attenders to meet their goal.

Nurses told us they were in regular communication with district nurses about the patients that they both treated. Sometimes frail patients had been seen out in public and might be considered outside the district nurses' responsibility for home visits, but they were not able to get to the practice in bad weather to have their dressings changed. A patient who suffered with agoraphobia was not always able to come to appointments, but was able to benefit from telephone discussions.

Tackling inequity and promoting equality

Staff were aware of patients for whom English was not their first language. They said they had access to a translation service if required but that most patients came with their own translator.

Staff were familiar with other cultural needs and could meet the needs of patients coming to them for the travel centre needing vaccinations. We found that staff knew their local disadvantaged people including residents of care homes, homeless people and seasonal travelling communities as well as immigrant workers.

The practice manager had gone to a local college to give a presentation about Summary Care Records to ensure that people not normally engaged with the practice should understand the issues and their rights.

Access to the service

There was level access from the street and all appointments were on the ground floor. In the waiting room there was a high desk around the receptionist but staff's voices could still be heard clearly when they answered the phone. There was an opening to a corridor separate from the waiting area to the side of the reception desk. This was provided with a shelf at a good height for any patient including wheelchair users to write and to speak to the staff without being heard by patients in the waiting room. Staff said they could offer a separate room for confidential discussion with patients if they wished. There were chairs of variable height and some with arms, to help patients with limited mobility.

Staff were aware of the parts of the building that could cause difficulty for patients with mobility problems because of narrow corridors and tight corners. Paramedics had needed specialist equipment to help a patient leave one treatment room. The practice was planning changes to the building that would improve access for patients. There was an accessible toilet which was serviceable although it would benefit from refurbishment. However, its sliding door had a lock that was difficult to operate.

There were treatment couches that could be raised and lowered, to be easier for patients to get on and off. There was a hearing loop at reception to help patients who used a hearing aid. It was not working properly, so a new one had been ordered, which showed staff awareness of patient requirements.

The practice had introduced a system of telephone triage by GPs for all appointment requests. Patients did not like this, so it was discontinued. A duty system had been introduced. There was a GP each day to deal with urgent appointments covering core contract hours from 8am to 6.30pm. There were also some same day non-urgent slots available. Patients told us it was a good system and that staff were prepared to flex it to accommodate a patient.

Good

Are services responsive to people's needs?

(for example, to feedback?)

GPs told us that although some patients still asked to see a named GP on the day, this could not always be delivered. Patients could always see a GP on the day, and could see their named GP if they were able to wait. Nurses told us they found the service is was flexible for patients, and they could give them the time they needed, and not be confined to 10 minutes. They found their patients liked this. This showed how the service was responsive to patients' needs.

The timing of appointments took into account bus availability. For example, buses came from some villages only on market day. The practice accommodated this rural requirement of patients although it put pressure on the staff on market day.

A new service had been introduced three weeks before this inspection for weekends. Appointments could be booked at Bideford and Barnstable hospitals run by an out of hours service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy gave clear guidance for patients and staff. It was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The policy was displayed in public places, including in the toilet where patients could make a note of contact details without feeling watched. Administrative staff were trained to de-escalate issues and ease the way to discussion of concerns. Two formal and five informal complaints had been recorded and responded to in line with the policy. These were included in the latest review, held annually to detect themes or trends. Minutes of team meetings showed that information and any learning had been shared amongst the team. The practice introduced a complaints and grumbles book to capture more patient comment.

The practice displayed requests a leaflet about the NHS complaints advocacy service to help any patient needing support to make a complaint.

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

South Molton Health Centre's stated aims were to provide high quality medical care in a safe and friendly environment which is accessible to all. GPs and nurses were working in accordance with this vision, stating their expectation was to provide flexible care focussed on patients' needs. Patients confirmed this was their experience.

The practice manager and GPs were working towards a formal practice business plan to further the development of the practice. They had undertaken 'away afternoons' to make progress with this and were considering sharing resources with a neighbouring practice.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a prescribing lead, one GP was the lead for safeguarding vulnerable adults while another was lead for child protection. All the staff who spoke with us were 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.

The practice manager was the lead for information governance (IG) and undertook the relevant training. She had completed the mandatory self assessment for the practice and communicated IG awareness via team meetings. She reviewed the process for shredding confidential waste by a company after shortfalls were identified. This was managed via the risk register and quality group meetings and demonstrated the practice's focus on patient confidentiality.

Leadership, openness and transparency

Weekly management meetings were held for the leaders of the nursing, administrative and reception teams. Staff issues were discussed and arrangements made to ensure suitable staff cover be in place for the week ahead with all tasks covered by competent staff. The management team had developed a set of core competencies to outline expected standards of behaviour across the whole practice, for partners and staff.

Nurses told us they attended nurse meetings within the practice and joined each other's clinics to learn from each other. Nurses were also sponsored by the practice to attend the local nurse forums.

Team meetings were held regularly and there had been a team building away day. Themes including the patient pathway had been considered using arts and crafts to demonstrate how the team worked together.

GPs had undertaken a Medical Protection Society exercise which involved peer to peer review of clinical record keeping. Feedback to one another was given at a meeting of the GPs.

Practice seeks and acts on feedback from its patients

Members of the patient participation group, called P3, told us the practice manager was very conscientious about working with patients and getting feedback from them. They had asked her to chair their two monthly meetings, which she continued to do. A GP always attended as well, they took turns so that all GPs had a connection with the group. Other team leaders sometimes attended.

The group were considering ways of widening the group of patients from whom they received feedback. Some patients kept in contact with the group by email but were unable to attend meetings. The members who spoke with us were pleased with their progress and agreed it was working very well. They told us they found the practice really did listen to them and tried to put their requests into practice. They gave the changes in the appointment system as an example. The practice had changed the appointment system, introducing a GP triage phone call. Patients did not like it, so they changed it again. They introduced closing the phone line over lunch time and putting on the ansa phone. Patients did not like it, so they stopped. They thought it very helpful that patients can phone the practice and speak to a GP. They appreciated that the practice would make small adjustments to make systems work for individuals.

The practice displayed requests for feedback in the waiting room, information about the P3, and a leaflet about the NHS complaints advocacy service.

Management lead through learning and improvement

The practice manager had carried out a self-assessment annually to identify training needs for the practice. A training skills log has been produced; all the skills needed

Are services well-led?

Good

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

were identified, and certificates shown as evidence that nurses were qualified to meet these needs. The log showed when updates to training were due. Staff were expected to check their own training needs before the regular nurses' meeting. One nurse had completed training for ear suctioning and was in the process of gathering costings for equipment and resources in order to make a proposal to the partners for offering the service. The lead nurse identified a shortfall as wound dressings were only offered one day per week when a suitably trained nurse was available. Training was undertaken by nurses so the service may be offered from Monday to Friday. Other skills needed for patient care were available.

An action plan had been put into practice during 2014 which had resulted in much learning and had resulted in embedding quality monitoring into the regular work of the practice. The final requirement of the action plan was for GPs to peer review their record keeping. This was planned to take place in the month following this inspection.

All staff had appraisals, with team leaders meeting with the practice manager for discussion of their performance and training plans, while they provide annual appraisals for their team.

Trainee GPs attached to the practice told us they had received good support and that the overall culture within the practice was supportive and friendly.