The London Road Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 The London Road Surgery on 25 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. We found that it was good for providing services to all of the population groups we looked at.

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.
- Generally risks to patients were assessed and well managed however a health and safety risk assessment had not been undertaken.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the partners and practice manager. The practice proactively sought feedback from staff and patients, which it acted on.
- Clinical governance was robustly monitored with an ethos of continuous improvement and learning.

Summary of findings

- Effective systems were in place to monitor and assess the quality service provision. High levels of performance and quality of care were evident across the processes and procedures at the practice.

We saw one area of outstanding practice:

- Cohesive leadership was in place that included staff at all levels. The leadership and culture had a positive impact on the delivery of care. All staff shared the practice objectives and worked towards them. Staff satisfaction levels were high.

However there was an area of practice where the provider needs to make improvements.

Importantly the provider should;

- Undertake health and safety and legionella risk assessments.

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 partners at the practice were focused on safety and adopted a pro-active approach to learning from incidents. Staff understood their responsibilities to raise concerns and to report incidents and near misses. Team meetings were used to cascade learning from incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff had been trained in safeguarding procedures and knew the different types of abuse. Children at risk and vulnerable adults were monitored and reviewed. Staffing levels were maintained and recruitment processes robust. Medicines were managed safely and securely stored. Infection control procedures were being followed. Health and safety and legionella risk assessments had not been completed. Staff had received chaperone training and followed procedures. Equipment in use was in sufficient quantities. Staff had been trained to manage medical emergencies.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality and performance was regularly monitored. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Staff had received appropriate training and it met the needs of patients. Staff were suitably qualified and received annual appraisals and personal development plans. Staff worked with multidisciplinary teams and other specialists. Information was shared appropriately with healthcare professionals. Staff had an understanding of consent and the Mental Capacity Act 2005.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in 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. People with caring responsibilities were identified and offered appropriate support.

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

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients generally commented that the appointment system met their needs. Reception staff supported patients to obtain appointments at times that suited their circumstances such as the elderly or young children. The practice sought feedback from patients through surveys, complaints and through the patient participation group, responding to ideas for improvement. Patients could obtain appointments with a GP of their choice on most occasions. Patients received continuity of care, with urgent appointments available the same day. The practice had satisfactory facilities and was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints took place with staff to prevent reoccurrences.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The four partners took responsibility overall and had oversight of all issues. Where responsibilities had been delegated to others they were monitored. There was evidence of regular structured meetings and staff received updates and feedback on the objectives and performance. The strategy to deliver this vision was regularly reviewed and discussed with staff. All staff spoken with felt involved in the future of the practice and were very complimentary about the leadership in place. Patients had been invited to comment on the future of the practice through surveys. High standards were promoted and owned by all practice staff and teams worked together across all roles. Managers dealt with underperformance in a fair and robust way. Staff appraisals had been completed for all staff. GPs sought patient views about their performance for their annual appraisals. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. Partners had oversight of complaints and took decisions to resolve them to the satisfaction of patients. An annual review of complaints took place to identify themes and trends. There was a high level of constructive engagement with staff and a high level of staff satisfaction. There was evidence of clinical and non-clinical audit taking place at the practice.There was a willingness to learn at all levels within the practice. External CCG locality meetings were attended by the GPs and practice managers to share learning and good 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

Good

The practice is rated as good for the care of older people. They maintained a register of those patients at risk of an avoidable hospital admission and put a care plan in place to reduce the risk of their health deteriorating. Each patient over 75 had a named GP and could see a GP of their choice whenever available. Home visits were available if needed. Multidisciplinary team meetings took place regularly where individualised care was discussed with other healthcare professionals. The practice had started a virtual ward to help support the elderly and enable them to receive care in their own homes. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of services including for patients with dementia and for those requiring end of life care. The practice was pro-active in identifying and involving relatives and carers to support patients. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Vaccination programmes were readily available to help keep patients healthy.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. A register of patients was maintained and their care and treatment discussed at multidisciplinary team meetings with other healthcare professionals to deliver a package of care. Care plans were in place to provide the most appropriate care and treatment and to avoid the risk of unnecessary hospital admissions. GPs and nursing staff had lead roles in chronic disease management and regularly monitored patients through annual health reviews. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Advice and guidance was readily available to help patients to manage their conditions and they were signposted to external organisations that could offer support. Patients with palliative care needs were regularly monitored and relatives and carers involved in the planning of their treatment.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high for all standard childhood

Summary of findings

immunisations and performance was regularly monitored. Appointments were made available out of school hours to provide flexibility and the premises were suitable for children and young babies. Contraception and family planning advice was readily available. Ante and post natal services were available and patients had access to the community midwife who ran a clinic each Wednesday morning. Children under the age of 16 were able to access appointments with a GP without their parent/guardian being present, in appropriate circumstances.

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. Students were able to register temporarily at the practice and could receive health checks and lifestyle advice. The practice was proactive in offering online services as well as a full range of health promotion and health checks that reflected the needs for this age group. Late night opening was available one evening each week until 9pm.

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 held a register of patients with learning disabilities and monitored their care and treatment. Annual reviews took place and these often involved relatives and/or their carers where relevant. Longer appointments were available for these reviews and for appointments. Patients were signposted to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and had received training relevant to their role. The practice did not have any patients living in vulnerable circumstances including homeless people and/or travellers but they were welcome at the practice.

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). A register was being maintained for patients with dementia and those experiencing poor mental health. Referrals were made to specialised memory clinics to support patients with dementia. Care plans had been put in place to monitor and review their condition to help ensure that their health did not deteriorate. Multidisciplinary

meetings took place to discuss each patients individual care and treatment requirements. Regular liaison took place with the local pharmacy to ensure medicines were being taken in line with the prescription to identify either under or over use of medicines. Mental health counselling took place on one day each week at the practice by a qualified counsellor. Health reviews took place annually or more frequently as required by the GP and/or nurse. The practice had ready access to the local mental health crisis team for children and adults and could refer patients requiring urgent support. The practice signposted patients experiencing poor mental health to various support groups and voluntary organisations including MIND.

Summary of findings

What people who use the service say

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 11 cards that had been left for us and reviewed the comments made.

The majority of the comment cards we viewed contained complimentary comments about the GP, nurse, reception staff and the services provided. Patients commented that staff generally were kind, caring and supportive. A few negative comments were made in relation to appointment availability and the time taken to get a prescription.

We spoke with three patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. Patients told us that they did not feel rushed during consultations and they said staff were kind and caring.

We were told that appointments were generally always available and they were rarely kept waiting. They told us that explanations were clear and care and treatment was delivered to a satisfactory standard.

Patient surveys reflected that patients were generally satisfied with the services they provided. Patients had also been asked to complete a questionnaire about one of the GPs to support their appraisal. Comments received were all positive and reflected that patients were satisfied with the care and treatment they had received.

The patient had an active patient reference group (PRG) that worked with the practice to discuss areas for improvement. Areas for improvement and views about the service were sought by email and members were kept informed about developments. Information was updated on the practice website. PRG members and patients were given the opportunity to provide feedback about the services they would like to see in place when the move to a new building took place.

Areas for improvement

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Action the service SHOULD take to improve
Undertake health and safety and legionella risk assessments.

Outstanding practice

Cohesive leadership was in place that included staff at all levels. The leadership and culture had a positive impact on the delivery of care. All staff shared the practice objectives and worked towards them. Staff satisfaction levels were high.

The London Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector accompanied by a GP specialist advisor.

Background to The London Road Surgery

The London Road Surgery is situated in Wickford Essex. The practice is one of 44 GP practices in the Basildon and Thurrock Clinical Commissioning Group (CCG) area. The practice has a general medical services (GMS) contract with the NHS. There are approximately 9900 patients registered at the practice. The practice undertakes minor surgical procedures.

The practice has four partners who are all GPs working at the practice. The practice uses two locum GPs on a regular basis and one additional locum at times of peak demand. There is a mixture of male and female GPs. The GPs are supported by three nurses, one of whom is a nurse practitioner. There is a practice manager and a reception manager and a team of reception and administration staff who undertake various duties.

The surgery is open Monday to Friday between 8.15am and 6pm and phone lines open from 8am to 6.30pm. There is a late night surgery on Tuesdays until 9pm. When on duty, each GP has a morning and afternoon surgery and the times are staggered to provide different options for patients. The practice is closed at weekends. The practice has opted out of providing 'out of hours' services which is now provided by another healthcare provider. Patients can also contact the emergency 111 service to obtain medical advice if necessary.

There has been no information relayed to us that identified any concerns or performance issues for us to consider an inspection. This is therefore a scheduled inspection in line with our national programme of inspecting GP practices.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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?

Detailed findings

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)

These questions therefore formed the framework for the areas we looked at during the inspection.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We then carried out an announced visit on 25 February 2015. During our visit we spoke with a range of staff including two partner GPs, a locum GP, a nurse, the practice manager and reception staff. We spoke with patients who used the service and a member of the patient participation group. We observed how people were being cared for and talked with carers and/or family members and reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice and we viewed them afterwards.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. They reviewed information from national patient safety alerts, significant events, accidents and incidents as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, knew how to report incidents and near misses and were encouraged to do so

We reviewed significant event records and complaints and could see that they had been investigated appropriately to identify safety concerns. We found that safety issues were discussed at management and team meetings and minutes were recorded. It was evident that there was a positive reporting culture and that the practice had managed safety concerns consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We viewed records of significant events and complaints over the last 12 months and found that they had been recorded in detail, analysed and investigated and learning identified.

The partners at the practice took an active role in any safety incident that had taken place and took the decisions in relation to remedial action and to drive change to achieve improvement. Significant events were a standing item on the agenda at the various meetings they held. These included partners, management and full staff meetings. The partners at the practice assumed responsibility for the learning from such incidents and it was evident that this was 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. They told us that the partners and managers at the practice encouraged them to raise safety issues and that there was a no blame culture in the workplace.

Staff used incident and complaint forms and sent completed forms to the practice manager who reviewed them and discussed them with the partners. We found that records had been completed in a comprehensive and timely manner. We saw evidence of action taken as a result. One such example was improved explanations to patients to ensure they were aware of the side effects of certain medicines. 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.

National patient safety alerts and information from the Medicines and Healthcare Regulatory Agency were disseminated by the practice manager to the GPs who provided a clinical input before taking appropriate action. Where relevant patients care, treatment and medicines were reviewed and changes made if required.

Reliable safety systems and processes including safeguarding

The practice had a lead for safeguarding who was one of the GPs. They had been trained appropriately in safeguarding procedures. All clinical staff at the practice had received safeguarding training. Other staff at the practice had received role specific training and were aware who led in this area and who to speak with if there was a concern.

Staff spoken with were aware of the different types of abuse that could take place in older people, vulnerable adults and children and who to contact externally if the need arose. A safeguarding policy was readily available to support staff and the contact details of other external agencies was easily accessible.

There was a system to highlight vulnerable children and adults on the practice's electronic records using a coding system. This included information to make staff aware of any relevant issues when patients attended appointments. The lead safeguarding GP was aware of vulnerable children and adults and monitored and reviewed them.

The practice had a system in place to report safety incidents such as complaints or significant events. This including safeguarding concerns in relation to children and young adults. Staff spoken with were aware of the systems to follow.

The practice manager was the first point of contact for all issues relating to safety. All incidents reported were discussed at a weekly management meeting but sooner if urgent. The practice manager took all appropriate initial

action to resolve the matter and then the issues were discussed at the meeting. Learning was cascaded to other staff at the practice either at team meetings or personally if required.

The partners took a pro-active role in resolving issues and made the final decision as to the most appropriate course of action. This included writing to or speaking directly with the person the subject of the incident, so that a proper explanation and/or action could be taken.

There was a chaperone policy in place and staff used as chaperones had received formal training. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Staff spoken with explained the correct procedures to follow and where they would stand for an intimate examination. If a chaperone was used the patient record was updated with the request and that one had been provided.

It was practice policy for chaperones to make an independent entry in the patient record of their observations of the consultation as soon after the examination as possible. This included where they stood, what they witnessed and whether correct procedures had been followed. A chaperone sign was visible in reception that advised patients that this service was available to them.

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. 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Patients were subject to six monthly reviews to ensure that medicines were effective and necessary. Blank prescription forms were handled in accordance with national guidance.

One of the GPs attended a quarterly prescribing meeting where the practice prescribing data was reviewed and discussed. This identified where savings could be made and to establish whether the use of the medicine was appropriate or could be stopped. Where a change was recommended this was discussed with the patient so that an explanation could be given before taking action.

The practice had established a service for patients to pick up their dispensed prescriptions at local chemists. Patients who were elderly or house bound had their medicines delivered to them by the pharmacy direct to their home. This facility was highlighted on the practice website as well as in the reception area.

Cleanliness and infection control

The practice had a lead for infection control who had undertaken training to enable them to carry out the role. All staff had received induction training about infection control specific to their role. An infection control policy and supporting procedures were available for staff to refer to and these were accessible from the practice computer system.

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 and staff knew the procedure to follow in the event of an 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.

The practice had a dedicated porta cabin attached to the main building designed for minor surgery such as the removal of lumps or the fitting of contraceptive devices. We found that despite having this facility one of the GPs preferred to undertake the fitting of contraceptive devices in the GP consultation room. The flooring of the consultation room was covered in carpet and this could not be easily cleaned and presented an increased risk of infection. All other GPs used the dedicated minor surgery facility.

We discussed this with the practice on the day of our inspection and they agreed to conduct all minor surgery in the facility designed for this purpose. In addition they agreed to implement an infection control checklist to ensure that the rooms were cleaned between each patient/ procedure. This was sent to us shortly after the inspection and were assured this was now in place.

Good

Are services safe?

A cleaning contractor was responsible for the cleaning of the general areas. A cleaning schedule was in place that outlined the type of cleaning, the materials to be used and the frequency. The quality of the cleaning was monitored by the practice manager and records were maintained.

The practice had not completed an annual infection control audit at the time of our visit and we pointed this out to the practice manager who agreed to undertake one. This was sent to us shortly after our inspection. The analysis of the audit revealed some areas for improvement and these had been actioned.

We observed the main building and the treatment rooms to be visibly 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 or infection control.

The practice had not undertaken a risk assessment for the management, testing and investigation of legionella (a term for a particular bacteria which can contaminate water systems in buildings and can be harmful). The practice agreed to undertake one in the near future.

Equipment

Staff we spoke with told us they had the appropriate equipment and in sufficient quantities to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all electrical and medical equipment was tested, calibrated and maintained regularly and records that we viewed confirmed this to be the case.

Equipment in use included weighing scales, spirometers, blood pressure measuring devices and a blood/sugar testing monitor. Also available for patients was a blood pressure monitoring device which was kept in the waiting room and patients were encouraged to use it.

Staffing and recruitment

The practice had a recruitment policy that described the procedure they followed when employing new members of staff. This included the need to undertake appropriate recruitment checks prior to employment, such as proof of identification, references, qualifications and registration with the appropriate professional body.

We looked at three staff files on the day of our inspection. They reflected that appropriate checks had been undertaken prior to employment and that their policy was being followed. This included criminal records checks through the Disclosure and Barring Service (DBS). Staff new to the practice, including locum GPs were required to undertake an induction process to familiarise themselves with the workings of the practice. They were supplied with an information pack for this purpose.

The practice manager told us that staff numbers and skills were monitored to ensure the needs of patients were met. Training was reviewed regularly to ensure there was an appropriate skills mix at the practice. Staff were able to cover for each other at times of annual leave, sickness or training. Staff we spoke with told us that there were sufficient numbers of appropriately qualified staff on duty to meet the needs of patients.

Monitoring safety and responding to risk

The practice had a health and safety policy that was designed to protect staff and patients at the practice. Staff had received health and safety training. A health and safety risk assessment had not been undertaken to identify risks to patients and staff.

Patients who were elderly, those with long-term conditions, were vulnerable or suffering from poor mental health were placed on a register and their condition regularly monitored and reviewed to reduce the risk of them deteriorating and to avoid unplanned hospital admissions.

The practice had access to the local mental health crisis team for patients experiencing deterioration in their mental health that may have put themselves and others at risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. 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. A system was in place to check whether emergency medicines were within their expiry date and suitable for use and this was checked monthly. All the medicines we checked were in date and fit for use.

We looked at whether staff had received training to manage emergencies and found that appropriate numbers of staff had received training in basic life support. Emergency equipment was available including access to oxygen and

Good

Are services safe?

an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Each GP at the practice had their own emergency bag which they took with them when away from the practice. We checked the contents of these bags and found that they contained recommended emergency medicines and they were all in date. The GPs were responsible for monitoring the stock and expiry dates of the medicines and records had been maintained.

A sign was displayed in the reception area that informed patients of the evacuation procedure in the event of a fire. Staff had received fire safety training. Fire extinguishers were readily available around the practice.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. These included power failure, adverse weather, unplanned sickness and access to the building.

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).

Regular clinical meetings took place and records were maintained. Where relevant new guidelines were discussed and disseminated. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

There was an effective system in place to monitor national patient safety alerts. These were sent to the practice and reviewed by the GP who made appropriate clinical decisions. The information was then disseminated to the nurse and other staff if relevant to their role. These were also discussed at clinical meetings. This helped ensure patients received effective consultations and treatment.

We found that assessments of patients took place in line with NICE guidelines. Where an assessment revealed a more complex diagnosis, patients were referred to specialists and other secondary care services in a timely manner and where urgent, often on the same day. The GP was responsible for the referrals and supported patients to choose and book a specialist of their choice.

The GPs and nurses specialised in a number of clinical areas such as diabetes, heart disease and asthma. This supported the needs of patients who were able to receive appropriate monitoring, along with advice and guidance as to how best to manage their condition and maintain a healthy lifestyle.

The practice computerised patient record system was used to identify those patients whose needs required more regular monitoring. This included those with long-term conditions, complex needs or those patients nearing the end of their lives. The records were coded in such a way that patients needing additional support could be easily identified. They were then included on a register and their care and treatment more regularly reviewed. This involved other healthcare professionals.

Care plans were then put in place and patients needs assessed on an individual basis. Use was then made of community resources so that patients could receive the most appropriate care and treatment, to prevent avoidable hospital admissions and to allow them to receive care in their homes as long as possible.

Management, monitoring and improving outcomes for people

The practice monitored their performance using the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually.

Data available to us for the year ending March 2014 reflected that the practice had achieved their targets against national screening programmes to monitor outcomes for patients. This included child immunisations, the numbers of patients with diabetes receiving an annual medication review, and the minimum standards for diabetes, asthma and chronic obstructive pulmonary disease.

The practice manager told us that their QOF performance was monitored monthly by them and information was cascaded to relevant staff at the practice who held responsibility for achieving targets. This included the partner GPs and nursing staff. We looked at the current data for this year and this reflected that the practice were on course to achieve and exceed the performance targets that had been set for them.

To improve outcomes for patients with diabetes and other long-term conditions, the practice had a system in place to encourage and remind patients to attend the practice so their condition could be monitored. Patients were contacted three times either by letter advising them that their review was due. If they had not responded they were then allocated an appointment and advised by letter with a request for them to confirm they would attend 72 hours before the allocated time. They found that using this method, more patients with long-term conditions attended for their review.

Good

Are services effective?

(for example, treatment is effective)

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice undertook clinical audits which were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The practice had undertaken a number of audits including medicines management and dementia coding.

If an alert was received from the Medicines & Healthcare products Regulatory Agency about a particular medicine staff made use of their computerised patient record system to check and audit those patients affected by the alert to ensure patients were not at risk. This often involved reviewing the medicines they were taking and discussing them with the patient and if necessary, prescribing an alternative.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with their training and this was being regularly monitored. The practice had decided that all staff would be trained in basic life support, safeguarding, manual handling, fire safety and information governance. Other training was role specific.

GPs and nurses at the practice specialised in a number of conditions including asthma, chronic obstructive pulmonary disorder, blood pressure management, diabetes and smoking cessation.

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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Appraisals were conducted by two members of staff and this was usually the practice manager and one of the GPs. Prior to the appraisal staff were asked to complete a self-appraisal form then attend for a formal meeting. Staff were encouraged to develop and expand their experience and training courses were agreed if it met the needs of the practice and the patients. Their performance throughout the year was graded and support and advice offered if required.

The practice had just begun trialling a 360 degree feedback for appraisals where other staff were invited to comment on the performance of their colleagues across key areas. If successful, there were plans to develop this to include other staff members in supervisory roles.

Staff spoken with told us that the appraisal system was fair and meaningful. Staff records reflected that appraisals were taking place annually. They also reflected that where under performance had been identified appropriate action had been taken to manage this.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. Training certificates were attached to their personal files to show that they were suitable qualified to carry out their role. They told us that they were encouraged to undertake their continual professional development in order to maintain their skill levels and to enable them to remain registered with their professional body.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries both electronically and by post. Patients discharged from hospital were reviewed to identify whether further support was required for them from community nurses.

Good

Are services effective?

(for example, treatment is effective)

All such correspondence was reviewed in the first instance by one of the partner GPs who was responsible for deciding whether any follow-up appointments or review of medicines where necessary. If so this was passed to administration staff who contacted the patient and made the necessary arrangements. Patient records were updated accordingly.

Information was received in a timely fashion form the emergency out of hours and 111 advice service. This was communicated to the practice by 8am the morning after the consultation so that the latest information about a patient was available. One of the GPs reviewed the information and made any clinical decisions that were necessary, then the patient record was updated.

The practice held quarterly multidisciplinary team meetings to discuss the needs of patients with complex needs, such as those with end of life care needs, long-term conditions or at risk of their health deteriorating rapidly. Care and treatment plans were put in place to manage their condition and to reduce the risk of unnecessary hospital admissions. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Patients with dementia had received an annual mental health review undertaken by the GP. Liaison took place with the dementia crisis team who helped to keep patients at home safely as long as possible. A mental health counsellor from 'Therapy For You' attended the practice one day each week to provide support for patients.

Information sharing

The practice used an electronic patient record system 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. The practice made use of the system to share information internally and with other healthcare providers such as the 'out of hours' service. This software enabled paper communications, such as those from hospital, to be saved in the system for future reference.

Patients were supported to use the 'choose and book' system when there was a need to refer them for specialist treatment. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff we spoke with told us that the system was effective and easy to use. Patients usually received the date of their appointment within two weeks of the referral. We were told that referrals were dealt with on the same day and that there was no backlog.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

There was a consent policy for staff to refer to that explained the different types of consent that could be given. For example, for all minor surgical procedures, the completion of a consent form was required. This covered the understanding of the procedure and any risks involved with it. A consent form had also been introduced for patients receiving holiday vaccinations.

Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent. Where there was doubt the procedure was delayed until the consent issue could be clarified.

Clinical and reception staff were aware of Gillick competence. This is where in some circumstances a child under the age of 16 can consent to receiving care and treatment without a parent/guardian being present. Where a child of this age was seen by a GP or nurse they were aware of the Gillick competence test, used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Clinical staff told us that patients with a learning disability and those with dementia were supported to make decisions through the use of care plans and with support from relatives and carers.

Health promotion and prevention

The practice had a range of information in both leaflet and poster format to provide patients with information to help them maintain their health. These included posters alerting

Good

Are services effective?

(for example, treatment is effective)

patients to the availability of flu and shingles vaccinations for the elderly and those vulnerable through long-term conditions or other reason. Posters about child flu vaccinations were also displayed.

There was also information available to support patients in managing their conditions such as understanding hypertension, dementia and diabetes. Other information available included advice on smoking cessation, maintaining a healthy weight, alcohol consumption, activity and exercise and travel immunisations.

One initiative that had been implemented was the use of their electronic patient system to identify persons at risk of developing diabetes. These patients were then contacted and offered advice and guidance to reduce the risk of the condition developing.

Patients identified as smokers were sent letters inviting them to attend a smoking cessation clinic and information about external support agencies that could offer them advice. Also included was a useful fact sheet with tips on how to give up smoking.

The practice offered testing for patients at risk of urinary tract infections. Patients could attend the practice and leave a urine sample and receive a result the same day. This supported those most vulnerable patients who were able to obtain an early diagnosis and prompt medicines to treat the condition. Same day chlamydia testing was also available for patients.

The practice offered a health check with the 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. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice was aware of the needs of their practice population and the strategy of the local Clinical Commissioning Group and this information was used to help focus health promotion activity. In relation to diabetes they had instigated an initiative to identify patients who might be susceptible to the condition in relation to their lifestyle and general health. They were then contacted and offered advice and support to change the way they lived to reduce the risk of developing the condition.

Patients with learning disabilities received an annual health check and more frequently if required. The practice's performance for cervical smear uptake was above the national average for the year ending March 2014. The practice was pro-active in following up patients who did not attend for their test.

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

The practice website contained useful information to patients on how to prevent and self-treat the more common illnesses and accidents. These included burns and scalds, chicken pox, cystitis, fevers, coughs and colds.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the need to treat patients with dignity, respect and to maintain their privacy. The reception was open plan and patients could use a touch screen facility to record they had arrived for their appointment. This allowed them an increased level of privacy. Patients seen at the reception desk were seen one at a time to reduce the risk of other patients hearing their conversation.

Staff were aware not to discuss private matters at reception and if a patient wished to discuss something in confidence thy were able to use a separate room. Patients were asked to approach the reception desk one at a time to reduce the risk of conversations being overheard.

The practice switchboard was located away from the reception desk and was shielded by a glass partition which helped keep patient information private.

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 each room so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and the majority were positive about the service experienced. Less positive comments were received about the appointment system and one example patient described difficulties in obtaining a repeat prescription. However there were no common themes to these. We also spoke with three 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.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour and this was also included in the practice leaflet and on their website.

We reviewed the information from the national patient survey (2014). The results of this survey reflected that a high percentage of patients compared with the local CCG average felt staff were kind and caring and treated them with respect.

Care planning and involvement in decisions about care and treatment

The NHS national patient survey 2014 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. Evidence reflected that they were not rushed when with the GP or nurse and that explanations about treatment were clear.

Data from the national patient survey showed 70% of practice respondents said the GP was good at involving them in care decisions and 73% felt the GP was good at explaining treatment and results. The corresponding data for the nurses at the practice was 77% and 82[WA1] %.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients who were elderly, those with long-term conditions or with complex issues were identified and recorded on a register. Their on-going care and treatment was discussed with them and they were involved in the care and treatment decisions and plans.

Patient/carer support to cope emotionally with care and treatment

Information was available to carers in the waiting room and reception area that signposted them to external organisations and support groups. This included emotional as well as financial support and where they could obtain equipment that may help them in their role as a carer.

Reception staff told us they tried to identify those people with caring responsibilities when they attended the surgery or when new patients registered. They were then offered additional support.

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 patients' needs and had systems in place to maintain the level of services provided. The practice was aware of their patient profile in relation to age, population group and medical conditions. Patients had been coded on the computerised patient record system so that they could respond effectively to their needs and monitor the effectiveness of the care and treatment they provided.

The practice monitored patients with long-term conditions such as chronic pulmonary obstructive disorder, diabetes and asthma. Regular health checks were available for them which included lifestyle advice to support them to manage their condition.

Patients at risk of deteriorating health were identified and placed on a register. Their care and treatment was coordinated with other healthcare professionals to reduce the risk of avoidable hospital admissions.

Family planning was available for patients who could book an appointment with the nurse to receive appropriate advice. Mothers and babies could attend to see the community nurse who attended the practice one day each week. Ante and post natal monitoring also took place along with immunisations for children in line with the national immunisation programme.

The nursing team provided advice on smoking cessation, diet and exercise, alcohol consumption and cervical smear testing. They also undertook minor surgical procedures such as the fitting of contraceptive devices and the removal of lumps or growths.

Patients suffering from poor mental health could see a trained counsellor who attended on one day each week. The practice also had access to the local mental health crisis team for those patients with urgent mental health needs.

Systems were in place for older people to access the care they needed. Patients over 75 had a named GP and received continuity of care. Home visits were available if they were housebound or had limited mobility. Services were provided so that the elderly were able to receive their annual flu vaccinations and there was a system in place to remind them when these were due.

Local chemists attended the practice to collect prescriptions on behalf of patients with limited mobility and this service extended to delivering their medicines free of charge to their home address.

The appointment system was effective for the various population groups that attended the practice. Appointments were available in the evening on a Tuesday up until 9pm. Longer appointments were available for patients with learning disabilities, those suffering from poor mental health and those with long-term conditions or complex needs.

Patients could obtain their test results between 2pm and 4pm each day. A system was in place to contact patients who had not called to obtain them and an adverse result had been received that required additional clinical input.

Patients we spoke with and comment cards we viewed reflected that the GPs and nurses always had time to listen to their concerns and they were not rushed.

The practice regularly sought feedback from patients through their patient reference group (a group of patients registered with a practice who work with the practice to improve services and the quality of care). They also gathered information form surveys and questionnaires and from the monitoring of complaints. Where improvement areas had been identified or suggested these were considered and actioned when relevant. They had also consulted patients about a move to a larger building, asking them what services they would like to see at the new premises. This was the subject of ongoing consideration.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed this training and had found it useful.

The premises and services had been adapted to meet the needs of patients with disabilities. The main building contained the reception and waiting room areas and some consultation rooms. These were spacious and could accommodate wheelchair users and those with limited mobility and there was easy access to the consultation rooms. Disabled patients or those with limited mobility were seen in one of the consultation rooms on the ground floor.

The building at the rear of the premises, used as a treatment area, was also spacious and allowed easy access

Good

Are services responsive to people's needs?

(for example, to feedback?)

for wheelchair users. A ramp was available as were supporting handrails for patients and the door had a 'push button' automatic opening sliding door. There were also sufficient numbers of parking spaces for patients to use in the car park at the premises. Accessible toilet facilities were available for the disabled and for parents/carers requiring baby changing facilities.

The practice had access to online and telephone translation services but there had not been a requirement to use them.

Access to the service

Appointments were available from 8.15am to 6.30pm on weekdays with a late evening on a Tuesday until 9pm. A minimum of three GPs were available daily rising to five during peak periods. Each GP had one morning and one afternoon surgery and the times were staggered to provide appointment options for patients. GPs carried out approximately 34 consultations each day cross the surgery sessions they ran. The practice was closed at weekends. During period of high demand, such as the winter season, a locum GP was often employed to cover an additional six sessions each week.

The practice operated a GP on call system where each day one of the GPs was allocated that role. This role was used to deal with telephone consultations, home visits and for general advice. The nurse at the practice also saw patients with minor illnesses and conditions so the GPs could concentrate on the more serious health conditions.

On a daily basis half of the appointment slots were reserved for patients requiring emergency consultations. Children, the elderly and those with long term conditions or who were vulnerable were given priority. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

The practice's extended opening hours on Tuesdays until 9pm were particularly useful to patients with work commitments and other patients who found it difficult accessing the practice during the day. An online booking system was also available for patients that registered to use the service.

Clear information was available to patients about appointments on the practice website and in the reception area. 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. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice.

Home visits were available for older people and those with long-term conditions. The practice also considered the needs of patients when booking appointments and offered earlier appointments to the elderly and outside of school hours to families, children and young people.

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.

Listening and learning from concerns and complaints

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

As there was a reception manager at the practice, all complaints were referred to them in the first instance and they were encouraged to deal with the more minor issues to the satisfaction of the patient concerned. The more serious complaints were handled by the practice manager and forms were readily available in the reception area for staff to hand to patients. Staff spoken with were aware of the complaints procedure and it was displayed in a prominent position in the waiting room area.

The practice website contained information for patients about the procedure to follow if they wished to make a complaint.

We looked at the records of complaints received in the last 12 months and found that they had been satisfactorily handled, dealt with in a timely way, analysed and learning identified. One such complaint led to the introduction of a consent form for patients to indicate they had understood a procedure and were aware of the risks involved. Staff we spoke with were aware of the learning from this complaint and told us that it had been discussed at a staff meeting.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had also conducted a complaints audit for the period April 2013 to March 2014 where 30 complaints had been analysed for themes and trends. This identified that clinical care was not the subject of complaint. All complaints had been categorised and it was clear from the analysis which complaints had been the subject of change for improvement purposes. The analysis revealed two main areas where patients felt the need to complain about. These were communicating test results and the booking of and waiting time for appointments.

As a result of this, these issues were discussed at practice and level and with the patient participation group. An action plan had been put in place for both areas of concern to try and achieve a reduction in the number of complaints for this issue. This included clearer information to be provided from the GP to the reception team, clearer details in patient records about test results and better use of text alerts to remind patients about their appointments to prevent patients failing to attend for their appointment.

Minutes of team meetings reflected that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

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 strategy and discussed with staff at team meetings. The practice had also identified a larger building nearby and planning was at an advanced stage to move there. This included providing additional services for patients with improved facilities. Staff and patients were being consulted so that the partners could consider and meet the needs of patients when planning their strategy.

Patients had been made aware of the move to the new premises and had been consulted about the services to be provided. This enabled the partners at the practice to design the premises to meet the needs of patients and to improve those existing services. Consultation with the patient reference group (PRG) had also taken place which helped the practice formulate the strategy for the transfer to the new premises.

We spoke with four members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw from the minutes of the meetings we viewed that staff were involved with the strategy and understood their roles and responsibilities in achieving the objectives.

We found that staff appraisals and job descriptions were linked to the vision and objectives set by the partners. Staff had been set individual role specific objectives that clearly impacted on the performance of the practice. Staff members felt that they were part of a team and working towards a common goal. They felt included, informed and motivated.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available to staff within the practice. We looked at a range of these policies and procedures and staff spoken with told us they had read and understood them. They were available for them on the practice computer system. The policies and procedures were subject to regular review.

There was a clear leadership structure with named members of staff in lead roles. One of the GPs was the governance lead, the lead nurse was responsible for infection control and the senior partner was the lead for safeguarding. We spoke with three members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. Clinical staff had been allocated the responsibility of the QOF targets and were working towards them. For example one of the nurses monitored the practice performance for achieving child immunisation targets. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had undertaken some clinical audits which it used to monitor quality and systems to identify where action should be taken. These included a medicines audit to identify value for money issues and whether patients were on the most appropriate medicines. Another audit dealt with medicine and national patient safety alerts where affected patients condition and treatment were reviewed to ensure it was safe.

The practice held regular partners, managers and staff meetings where governance arrangements were discussed. We looked at minutes from several meetings and found that performance, quality and risks had been discussed, including the learning from significant events and complaints.

Leadership, openness and transparency

The leadership, governance and culture at the practice were used to drive and improve the delivery of high quality person-centred care. There were four partners at the practice who provided clear, visible leadership. Each had defined areas of responsibility and worked together towards the vision and objectives they had set. The practice manager and nurses also held specific leadership roles and worked with the partners in a collaborative way.

Weekly partners meetings took place with the practice manager attending once a month or when necessary. These were used to discuss the overall strategy of the practice and any other leadership issues.

Are services well-led?

Good

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

A weekly management meeting took place attended by the partners, the practice manager, the salaried GP and the nurse practitioner when required. Information from the partners meetings was cascaded and discussed where relevant

Practice team meetings took place quarterly managed by the practice manager and with as many clinical and non-clinical staff attending as was available. Although the partners only attended on occasions, information was cascaded to all staff that was relevant to their role or that provided direction and issues about the objectives and vision of the practice. This organised approach reflected that there was effective leadership in place and that there was a consistent flow of information between the partners and the staff working at the practice.

Minutes of each meeting that took place were recorded and disseminated to all staff. Relevant topics from each of the different meetings held at the practice were cascaded to staff if it applied to them. Those unable to attend could easily access the minutes on their computerised IT system. We viewed the contents of these minutes and found that a range of topics had been discussed including an update on performance, learning from complaints and significant events, good practice and other issues relevant to the provision of quality care and treatment for the patients.

There were high levels of staff satisfaction with consistently high levels of constructive staff engagement. Staff we spoke with all commented on the quality of the leadership at the practice including the positive changes implemented by the practice manager who had joined the practice 18 months ago. Staff displayed knowledge about the direction in which the practice was travelling, the areas for improvement and how their roles linked to the provision of high quality care and treatment. Staff told us that the practice was open and transparent and a no blame culture present throughout. They said they felt confident that they could raise any issue and that it would be dealt with professionally without fear of intimidation or reprisal.

We also found that regardless of the position held at the practice, where under performance had been identified, it had been recorded and dealt with in a fair but robust manner. Record keeping about under performance was transparent and made available to us. This reflected that the partners and managers at the practice were open and transparent about all issues and prepared to take action if necessary. This was balanced with positive assessments of staff members at the time of their appraisal where we found that several members of staff had been graded as exceeding the requirements of their role. Staff spoken with told us that the appraisal system was meaningful and fair.

We found that complaints and significant events had been recorded in an open way. Staff spoke of a no blame culture and although there were several complaints made in the year 2013 to 2014 and 2014 to date, they had been recorded, analysed and investigated effectively. The partners at the practice had oversight of the complaints and took the decisions in relation to any proposed action. Where action was required to prevent recurrence this took place in a timely manner and was recorded.

The practice manager was responsible for the policies and procedures in place at the practice. We reviewed a number of policies and found that they were bespoke to the practice and had been reviewed. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to access these policies if required and had their own copy of the handbook.

Seeking and acting on feedback from patients, public and staff

The practice had a number of different methods of obtaining feedback from their patients. There was a patient survey that covered the staff and the services provided and there was a GP survey where patients were asked to comment on the performance of the GPs. Complaints were also monitored for improvement opportunities.

The practice had an active patient reference group (PRG). The purpose of this group is to ensure that registered patients are involved in decisions about the range and quality of services provided. Due to difficulties in achieving attendance at face to face meetings the practice ran a virtual group who were contacted by email on a regular basis and invited to contribute ideas for improvement and to help design a patient survey.

The practice had tried to ensure the participants were reflective of the different types of patients registered at the practice so that a range of views could be obtained. This enabled them to obtain feedback from a variety of age groups and medical conditions, including those suffering with long term conditions and those with caring responsibilities. They were contacted regularly via email,

Are services well-led?

Good

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

updates were received and acted upon and minutes of meetings and survey results were cascaded to them. These were also made available to patients on their practice website and in the reception area of the practice.

The practice had identified an opportunity to move to a larger building nearby and to expand on the services they were already providing. To help inform their planning and after consulting PRG members, they had conducted a patient premises consultation questionnaire to try and identify the services their patients would like to see and how they should be delivered. There were 4218 questionnaires distributed to patients and a 19.2% response rate was received. Ideas and suggestions were being considered in the strategy for the future.

The NHS conduct independent surveys of patients about their practice annually. The last survey took place in 2014 and 257 questionnaires were sent out to patients. The return rate was 44%. The majority of the replies received reflected that patients were satisfied with the services provided. These included 76% being seen within 15 minutes of their appointment time, 86% being able to get an appointment or see or speak to someone and 83% describing their overall experience of the practice as good.

An area for improvement identified by the survey revealed that 44% with a preferred GP got to see or speak to that GP. The practice was aware of the results of this survey but information was not available to evidence show they were trying to improve in the areas identified. However it was noted that previous surveys dating back to 2012/13 had detailed action plans that they were still working towards achieving. We did acknowledge that the practice were planning a move to larger premises. As a result of this they were concentrating their efforts on assessing the feedback from patients as to the type of services they wished to be in place at the new premises, obtained from a patient questionnaire. As a part of this process they were also looking at whether feedback from previous surveys should impact on their future planning.

The practice had implemented the NHS Friends and Family test for the month of January 2015. This test provides patients with the opportunity to provide feedback on their experience at the practice. It asks patients if they would recommend the services they have used and offers a range of responses. It provides a mechanism to offer both good and poor patient experience. The practice received 27 replies and the results indicated that 85% of patients were extremely likely or likely to recommend the practice. The results were displayed in the waiting room and on their website.

In April 2014 two of the GPs were due for their annual appraisal so the practice sought the views of their patients about them using a questionnaire. They received 73 responses and the analysis revealed that 100% of the patients surveyed, would be happy to see that GP again and had confidence in the care given. We were told that this type of survey would take place annually for each GP at the time of their appraisal. This frequency is over and above what is expected of appraisals for GPs who are only required to seek patients views once every five years when their re-validation is due.

They had also conducted a patient survey/feasiblilty in April 2014 to identify whether further extended opening hours would be of interest to patients in addition to those already in place on Tuesdays until 9pm. The questionnaire also covered whether Saturday opening was a service that patients would like provided. There were 100 patients surveyed and 56 replies were received. Most indicated that they were happy with the surgery hours and the one late evening each week. There was some interest expressed in additional late hours including appointment availability on a Saturday. The practice was considering these findings in their long term planning.

They also sought ideas for improvements from their staff both informally, at team meetings and when they received their annual appraisals. Staff told us they were encouraged to give feedback and discuss any concerns or issues with colleagues and management. The minutes of team meetings reflected that performance issues were discussed in order to identify areas for improvement. One example was in relation to a staff member who had suggested that chaperones make independent notes on a patient record when they had been present at a consultation.

Complaints were recorded, analysed and areas for improvement identified. This included improving the information supplied to receptionists from GPs about patient test results and staff rota changes during periods of high demand. The practice also undertook an annual review of all complaints to establish whether they had been handled in line with their policy and standards and to look for patterns and themes so that steps could be taken to prevent reoccurrence.

Are services well-led?

Good

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

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 four staff files and saw that regular appraisals took place which included each member of staff being graded on their performance. Training and development had been discussed and personal development plans and objectives put in place where necessary. Training needs had been identified and organised so that staff could improve on the way they delivered services.

Staff told us that the practice was very supportive of training and that time to learn sessions had been arranged for them each month.

The practice had completed reviews of significant events, accidents and other incidents and shared with staff at meetings or informally. All staff had been trained in their computerised electronic health record system and used it frequently to share learning and good practice.

An annual review of the complaints received took place that identified themes and trends. These were shared with the patient participation group and staff at team meetings and actions implemented to achieve improvements.

The GPs, nurses and practice manager all attended local and area meetings to discuss good practice with other healthcare professionals. Any relevant learning was cascaded to their staff accordingly.