Kelvedon and Feering Health Centre

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

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Overall summary

Letter from the Chief Inspector of General Practice

We conducted a comprehensive announced inspection on 11 March 2015 under the new approach.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings 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, addressed and shared with staff during meetings.
- Risks to patients were assessed and managed.
- 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 readily available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should

Summary of findings

- Ensure that regular infection control audits, including audits in relation to minor surgical procedures are carried out to test the effectiveness of infection control policies, procedures and practices.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were generally average for the locality and where there were areas for improvement the practice was proactive in dealing with these. Staff referred to guidance from National Institute for Health and Care Excellence and we saw evidence from audits it was used routinely to improve care and treatment outcomes for patients. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and where further training needs had been identified and was planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to ensure that patients received effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from patient surveys showed that patients rated the practice higher than others for several aspects of care, such as how GPs and nurses explained their care to them, involving them in making decisions and listening to them. 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. We received positive remarks on the comment cards about the care people experienced at the practice, and the people we spoke with during the inspection confirmed this.

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 NHS England Area Team and the local Clinical Commissioning Group

Summary of findings

(CCG) to secure improvements to services where these were identified. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice had participated in the local CCG plans to minimise the impact of increased patient demand on local Accident and Emergency services over the Easter weekend by providing enhanced services. The practice planned to provide appointments between 9am and 12pm on Easter Saturday.

The majority of patients said they could make an appointment with a named GP and that there was continuity of care, with emergency appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and staff knew their responsibilities in relation to this. There was a clear leadership structure and staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

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

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and were included on the practice's 'unplanned admissions avoidance' list to alert staff to people who may be more vulnerable. The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its flu vaccination programme. The practice nurse had arranged to attend patient's homes if their health prevented them from attending the clinics at the surgery. The practice worked with a local care home to provide a responsive service to the people who lived there.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual and half yearly reviews of their health. Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

People whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses who arranged visits to them at home (including patients in the local care home the practice supports). Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be booked in person or by telephone. Appointments could be booked up to two weeks in advance.

Information and advice was available to promote health to women before, during and after pregnancy. Expectant mothers had access

to midwife clinics every week. The practice monitored the physical and developmental progress of babies and young children. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect.

Records showed that looked after children (such as those in foster care / under the care of the Local Authority), those subject to child protection orders and children living in disadvantaged circumstances were discussed and any issues shared and followed up at monthly multi-disciplinary meetings. GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group 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. Appointments could be booked online, in person or by telephone. Appointments could be booked up to two weeks in advance.

Information about annual health checks for patients aged between 40 and 74 years was available within the practice and on their website. Nurse led clinics were provided for well patient health checks. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the various vaccinations available including diphtheria, tetanus, polio, and hepatitis A was available on the practice website. When patients required referral to specialist services they were offered a choice of services, locations and dates through the choose and book system.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of patients

Summary of findings

who had learning disabilities. All patients with learning disabilities were invited to attend for an annual health check. The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. Patients were referred to local counselling sessions where appropriate and patients were provided with information how to self-refer should they wish to receive counselling.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at CQC comment cards patients had completed. The responses received were overwhelmingly positive with all those who completed about the care and treatment they received and the kindness of staff at the practice. A number of patients commented about the difficulties they had in accessing appointments at the practice and reported that they often had to wait days or weeks for routine appointments.

We also spoke with four patients, Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Data available from the NHS England GP patient survey showed that the practice scored in the upper range nationally for satisfaction with the practice, with many patients reporting satisfaction with the way they were treated by staff, involved in decision making and feeling listened to. Some patients also reported difficulties in accessing appointments.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that regular infection control audits, including audits in relation to minor surgical procedures are carried out to test the effectiveness of infection control policies, procedures and practices.

Kelvedon and Feering 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 specialist advisor.

Background to Kelvedon and Feering Health Centre

Kelvedon and Feering Health Centre is located on the High Street in the village town of Kelvedon, which is geographically situated between Chelmsford and Colchester. The practice provides services for approximately 4,943 patients living in Kelvedon and surrounding villages including Tiptree, Silver End and Witham. The practice holds a General Medical Services (GMS) contract and provides GP services commissioned by NHS Mid Essex Clinical Commissioning Group.

The practice is managed by one GP supported by clinical staff; one salaried GP, one locum GP, two practice nurses who work part time, one healthcare assistant and one phlebotomist. The practice also employs a practice manager, a deputy practice manager, five reception staff, two secretaries and one administration staff.

The practice is open from 8.30am to 1pm and 2pm to 6.30pm on weekdays. GP appointments are available between 9am and 11.50 am, and between 2pm and 6.20pm. Nurse led appointments and clinics are also available with ante-natal clinics held on alternate Thursdays and childhood immunisations clinics held every Wednesday morning. Routine appointments can be pre-booked up to three weeks in advance in person, by telephone or online. Home visits and telephone consultations are available daily as required.

The practice has opted out of providing GP services to patients outside of normal working hours such as evenings and weekends. During these times GP services are provided by Primecare Primary Care, an out-of-hours advice, emergency and non-emergency treatment service. Details of how to access out-of-hours advice and treatment is available within the practice, on the practice website and in the practice leaflet.

Why we carried out this inspection

We inspected Kelvedon and Feering Health Centre 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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 March 2015. During our visit we spoke with the senior GP, locum GP, practice nurse, the phlebotomist and reception staff. We spoke with four patients who used the service. We talked with carers and/or family members and reviewed anonymised personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety including incidents, comments, complaints and national patient safety alerts. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. From the minutes of practice meetings, communicated emails to staff and through discussion with staff we saw that information was shared with staff so as to improve patient safety.

Complaints, accidents and other incidents such as significant events were reviewed regularly and discussed at practice meetings to monitor the practice's safety record and to take action to improve on this where appropriate. Staff we spoke with could give examples of learning or changes to practices as a result of complaints received or incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Through discussions with staff and a review of records we saw that accidents, significant events and any other safety incidents were fully investigated. A root cause analysis was carried out to determine where improvements could be made and to identify learning opportunities to prevent recurrences. We saw that incidents and significant events were discussed with staff at regular meetings. Where areas for improvements were identified these were reviewed to help ensure that learning was imbedded into the practice. We saw examples of where practices had changed following investigations of significant events.

For example following an incident where reception staff provided inaccurate information about a patients test results the practice introduced a system whereby only clinical staff discuss the results of tests with patients.

The practice had a 'no blame' policy and staff including receptionists, administrators and nursing staff told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Practice training records made available to us showed that all staff had undertaken relevant role specific training on safeguarding adults and children. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had a designated lead for safeguarding vulnerable adults and children who had oversight for safeguarding and acted as a resource for the practice. From training records viewed we saw that the lead had undertaken appropriate safeguarding training, including level 3 safeguarding children training. Staff we spoke with knew who the lead was and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example looked after for children or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed at weekly GP meetings and monthly multidisciplinary team meetings, which were attended by health visitors, district nurses and school nurses. We looked at the records from these meetings and found that information was shared with the relevant

agencies, reviewed, followed up, and appropriate referrals were made as required. The practice had conducted an audit around safeguarding children and young people in 2014 to ensure that referrals were made and followed up appropriately. The audit showed that the practice was meeting the majority of outcomes and where areas for improvements had been identified these had been actioned.

A chaperone policy was in place and details about how to request a chaperone were visible in both waiting room noticeboards and in consulting rooms. (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). The chaperone policy described the clinician's responsibilities for determining when a chaperone would be needed. The policy covered chaperoning a patient in their own home. Where a chaperone was deemed appropriate but unavailable consultations should be rescheduled unless in emergency situations where to do so would adversely impact on the health of the patient.

Chaperone duties were undertaken by dedicated staff who had undertaken training and for whom criminal records checks had been carried out with the Disclosure and Barring Service (DBS). Staff we spoke with were aware of their roles and responsibilities when acting as a chaperone during patient consultations. Patients we spoke with were aware that they could request a chaperone during their consultation, if they chose to.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on the practice electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that staff had undertaken training in the use of the electronic system. We saw that records were regularly reviewed to assess their completeness and that action had been taken to address any shortcomings identified.

Medicines Management

Medicines were managed safely so that risks to patients were minimised. There were suitable arrangements for secure storage of medicines, including vaccines, controlled drugs, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in the correct quantities and in date.

The practice followed national guidelines around medicines prescribing and repeat prescriptions. We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for antibiotics, sedatives and non-steroidal anti-inflammatory medicines were similar to or better than the national average.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directives and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines such as medicines used in the treatment of terminal and life limiting illnesses, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. There were arrangements in place for the handling and storage of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). We saw that these were stored securely and regularly checked. However these medicines were not recorded in a controlled drugs register as required under the Misuse of Drugs Regulations 2001. The practice manager provided evidence that an appropriate controlled drugs register was purchased shortly after our inspection visit.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had robust arrangements for reviewing patients with long term conditions to ensure that the medicines they were prescribed were appropriate and that risks were identified and managed. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed leaflets and posters. Patients could order repeat prescriptions in person, by fax, post or online through the

secure clinical electronic system (Systmone) (for patients who were registered for online access). Through discussion with staff including the GPs we found that there were arrangements for ensuring that patients' therapeutic blood levels were routinely monitored to ensure that medicines were prescribed safely and effectively. Staff told us that they proactively followed up on patients to advise them to contact the practice for blood test results and reviews.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us that that the repeat prescription service worked well and they had their medicines in good time.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients and staff against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had in place infection control policies and procedures for staff to follow, which enabled them to plan and implement measures for the control of infection. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. All clinical staff had undertaken infection control training and staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. All staff undertook regular hand hygiene training and staff were provided with appropriate personal protective equipment including gloves and aprons.

The practice employed a cleaning contract company for general cleaning. We saw there were cleaning schedules in place for general and clinical areas. The practice nurses told us that they were responsible for cleaning the treatment room in between patient consultations. Nursing staff and the practice manager told us that regular visual checks were carried out on premises, equipment etc. to ensure that they were clean, however these were not recorded.

One practice nurse had been identified as the clinical lead for infection control supported by the practice manager and had they undertaken further training to enable them to provide advice on the practice infection control policy. Through discussion with the practice manager and a review of records we saw that the last infection control audit had been carried out in 2013 from which an action plan was developed to plan and achieve the required improvements. We saw that the majority of these actions had been acted upon and that there were plans to make improvements, which related to changes within the environment in line with the landlord's refurbishment plans for the building.

The practice carried out minor surgical procedures such as injections and skin excisions. These procedures were carried out in the practice treatment room. The GP told us that the last audit of surgical procedures had been carried out some years previously and that no areas for improvements had been identified. The documents relating to the audit were not available and the GP told us that another audit would be carried out in the near future.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales and thermometers were periodically checked and calibrated to ensure accurate results for patients.

We saw records showing that other equipment required for the safe running of the practice, including fire detecting and fire fighting equipment was checked and replaced as required. Portable electrical equipment was PAT tested annually. PAT testing is an examination of electrical appliances and equipment to ensure that they are safe to use.

Staffing & Recruitment

The practice had robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. The practice recruitment policy set out the standards it followed when recruiting clinical and non-clinical staff. The majority of staff had worked at the

practice for a number of years and documents relating to their recruitment were not available. We looked at the records for four members, one of whom had been employed within the previous year. We saw evidence that appropriate recruitment checks had been undertaken prior to employment. Employment references and criminal records checks were in place for this individual. There were procedures in place for managing under-performance or any other disciplinary issues.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. At the time of our inspection there were two full time equivalent GPs with a practice patient list of just under 5,000 patients. GPs and the practice manager told us that they worked to ensure that they provided a flexible and safe service to patients and a nurse practitioner was due to start work at the practice imminently. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures or adverse weather conditions). Staff told us that they would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, of which staff were aware. We saw that a health and safety risk assessment was being carried out to help identify risks to staff and patients.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they aware of these procedures. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would treat and escalate concerns about adults or children or a patient who was experiencing a physical or mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing all staff had received training in basic life support. Emergency medicines and oxygen was available at a dedicated place within the practice as were 'grab kits' containing medicines to treat anaphylaxis (severe allergic reaction). All staff asked knew the location of these medicines. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified key members of staff and their roles and responsibilities in identifying and managing risks to the provision of service from the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained details of the relevant people to contact in the event of any incident, which may disrupt the running of the day-to-day operation of the practice.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw that the fire safety and evacuation procedure was displayed at fire exits and throughout the practice waiting areas and corridors. Staff we spoke with were aware of the procedures to follow in the event of a fire or other untoward event which would require the building to be evacuated.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information and new guidance were made available in information folders and shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments.

We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance assessing and treating patients with long term conditions such as diabetes were generally in line with that the local Clinical Commissioning Group (CCG) averages. We saw that where performance fell below the local or national averages that there were arrangements to make the necessary improvements. For example performance in relation to reviewing patients with diabetes and respiratory illnesses such as asthma and chronic obstructive airways disease (COPD) were lower than expected. The practice manager explained that this was due in part to a period of staff long term sickness within the previous year. We saw that staff were working proactively to encourage patients to attend appointments for reviews. The practice manager told us that when the newly appointed nurse practitioner commences work at the end of the month that improvements would be made in these areas.

The practice GPs and practice nurses took a lead role in specialist clinical areas such as learning disabilities, diabetes, heart disease and asthma. The practice nurses carried out reviews for patients with long term conditions and carried out well man and well woman checks through pre-booked appointments. This helped the GPs to treat patients with more complex medical conditions.

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

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management.

The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. The GPs told us clinical audits were often linked to medicines management information, safety alerts. We looked at the records for one completed clinical audit cycle, which had been carried out around the use of Ezetimibe in the treatment of patients with high cholesterol where other statins were contraindicated. Patients who were prescribed this medicine were identified and monitored to see if they had achieved the target cholesterol reduction. Where the prescribing of Ezetimibe had not achieved the expected cholesterol reduction the medication was discontinued, which is in line with current National Institute for Health and Care Excellence (NICE) guidelines, in the best interests of patients and cost effective.

We looked at the data and information we held about the practice. This included information taken from the Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was generally in line with the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as dementia, learning disabilities and mental health disorders. We saw evidence that where the practice scored below the national average that staff were proactive in making the necessary improvements. For example the practice scores for immunisations, vaccinations and cervical screening were lower than the average. We saw evidence that both the GPs and practice nurse were proactive in following up on patients who had failed to attend appointments and that this had improved the uptake of both vaccination and cervical screening

Good

Are services effective?

(for example, treatment is effective)

appointments. The practice kept a register of patients who were receiving palliative care and treatment and were monitoring and planning care in line with the requirements of these services.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Staff described the process for ensuring that repeat prescriptions were checked and reviewed and the processes for alerting the GPs if they had any concerns about repeat prescriptions. The computerised system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs reviewed the use of the medicine in question, prescribed alternatives or, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs and reviewed their treatments appropriately.

Effective staffing

The practice employed staff who were appropriately skilled and qualified to perform their roles. Appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for four members of staff. We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw that staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Staff we spoke with told us that the GP provided opportunities for learning and that they undertook a range of online and face-to-face training. Records we viewed confirmed this.

All new staff underwent a period of induction to the practice. Support was available to all new staff to help them settle into their role and to familiarise themselves with relevant policies, procedures and practices. We spoke with one member of staff who told us that they had a tailored period of induction with support from more senior colleagues.

Individual staff performance was assessed and training and development needs were identified through an annual appraisal system. Staff had personal development plans that detailed their planned learning and development objectives, which were kept under review. We saw that where staff had identified training interests that arrangements had been made to provide suitable courses and opportunities. The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had dedicated leads for overseeing areas such as safeguarding, infection control, palliative care and learning disabilities. The practice nurse had undertaken specific training in health promotion and the treatment of minor illness such as, acute asthma, smoking cessation and sexual health screening. The nurse provided services including well person checks, long term condition reviews, family planning and cervical screening. This enabled the doctors to focus on more complex problems and conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital discharge, out of hour's providers and the NHS 111 summaries were reviewed and actioned on the day they were received.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients including those with end of life care needs, vulnerable families and children on the at risk register. These meetings were attended by

Good

Are services effective?

(for example, treatment is effective)

district nurses, social workers and palliative care nurses where decisions about care planning were documented in a shared care record. We looked at the records for the last four meetings and found that detailed information was recorded, reviewed and shared to ensure that patients received coordinated care, treatment and support.

The GP told us that they held regular meetings with the care home where they had patients. They told us that this helped to ensure good working relationships to improve outcomes for patients. The GP confirmed that the details of these meetings were not recorded so unavailable to view.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had undertaken training on the system. GPs and nurses we spoke with told us that information was accessible to help them make decisions and to plan and deliver effective care and treatment.

There was a system for making sure test results and other important communications about patients were dealt with. The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, such as those receiving end of life care, vulnerable patients and those identified as at high risk of unplanned admission to hospital. We saw that treatment records for patients who had used the 'out-of-hours' service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment.

The practice maintained registers for patients with life limiting illnesses, those receiving palliative care and treatments and patients with learning disabilities. GPs and nurses at the practice worked closely with Macmillan nurses and other agencies who support people with life limiting illnesses. They held a monthly palliative care meeting to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs.

Staff were alert to the importance of patient confidentiality the practice had appropriate policies and procedures in place for handling and sharing patient information.

Consent to care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children. The nurse we spoke with told us that they obtained parental consent before administering child immunisations and vaccines.

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff we spoke with were aware of the Mental Capacity Act 2005 as it relates to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in the person's best interests.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health promotion and healthy lifestyle choices available within the waiting rooms, reception and entrance hall where patients could see and access them. On the day of our inspection the practice was promoting the national 'No Smoking Day' and a range of information and advice leaflets were available and patients were signposted to the help available.

We saw information about mental health, domestic violence advice and support that was prominently displayed in waiting areas with helpline numbers and service details. There was information and guidance available on diet, smoking cessation and alcohol consumption. There was information available about the local and national help, support and advice services. This information was available in written formats within the practice. Large print documents and information in languages other than English were available if needed.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or

Good

Are services effective?

(for example, treatment is effective)

nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Nurse led clinics and pre-booked appointments were available including sexual health, family planning and menopausal advice, heart disease prevention, diabetic and asthma clinics.

The practice's performance patient reviews for diabetes were lower than local and national averages. The practice acknowledged that there had been difficulties carrying out reviews, in part due to the changes within staffing levels following the resignation of two partners within the previous 12 months. Staff were working proactively following up patients who had not attended reviews and had made some improvements in this area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Childhood immunisation clinics were held each Wednesday morning. Data we looked at before the inspection showed that the practice was performing in line with the average of other practices in the area for take up of childhood immunisations. We saw that the GPs and practice nurse were working proactively to follow patients who failed to attend appointments.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 24 CQC comment cards that patients had completed and spoke in person with four patients. The response from patients was overwhelmingly positive with all patients reporting that staff at the practice were helpful and good at listening to them. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. The patients who completed comment cards said they felt the practice provided consistent and excellent care and treatment.

We reviewed the most recent information available from the national patient survey, which was carried out in 2013. We saw that 70% of patients would recommend the practice and approximately 90% of patients reporting that GPs and nurses were good at listening to them and treating them with care and concern. We also looked at the results of the 'I Want Great Care' Friends and Family Test, which patients completed regularly. We saw form the results of these that the practice had scored consistently highly since November 2014 with 95% of patients saying that they would be extremely or very likely to recommend the practice. Many patients who participated in the test commented very positively about the friendliness of staff and the reported that they were treated with compassion and kindness.

Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity. Reception staff told us that where patients wished to speak privately to a receptionist, they were offered the opportunity to be seen in another room. During the inspection we spent time in the reception area. This gave us the chance to see and hear how staff dealt with patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients.

We observed that it was practice policy that GPs and nurses came to waiting areas and escorted patients to the consultation and treatment rooms. We saw that this helped staff assess any needs such as where a patient may need assistance with mobility or bringing young children to the consultation rooms.

We saw that individual birthday cards were sent out to patients 65 years and older and these were used to communicate and remind patients about medicine and routine health checks, flu, pneumococcal (pneumonia) and shingles vaccinations.

There were signs in the waiting areas and consulting rooms explaining that patients could request a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a range of anti-discrimination policies and procedures and staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The National Patient GP survey information we reviewed showed that patient's responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example,

Good

Are services caring?

approximately 89% of practice respondents said the GP was good at explaining treatment and results and that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that 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. They told us that GP's were extremely conscientious, caring and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards we received was also overwhelmingly positive and each of the 24 patients who responded told us that they were happy with their involvement in their care and treatment.

The practice identified vulnerable patients and kept a register. The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older people, those living in care homes and vulnerable at risk patients. This monitoring identified patients most likely to have an unplanned admission to hospital. Where patients were identified as vulnerable care plans were implemented, which were discussed and reviewed at multidisciplinary team meetings to help ensure that patients had appropriate support systems in place to help reduced unplanned admissions to hospital.

Staff told us that all of patients registered with the practice were English speaking. They told us that translation services would be made available for patients who did not have English as a first language. The practice easy-read invites to send to patients with learning disabilities. These documents described with pictures and photographs what the reviews involved such as weight monitoring, blood tests and reviewing medication. These were sent out to patients and/ or their carers. We saw that patient's families had welcomed these.

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and carers were provided with information and support to access local services and benefits designed to assist carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Information leaflets were available which described Advanced Directives (Living wills) and how patients could plan and make decisions about what treatments they would not wish to receive in the future. The information explained how a patient could register or change their decisions and both the GPs and patients responsibilities. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to develop care plans and help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families.

Staff told us families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation at the practice or a home visit where this was more appropriate. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations who deal with emotional issues such as bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients.

The practice utilised electronic systems for making referrals through the Choose and Book system. (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 reported that this system was easy to use.

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

The practice had participated in the local CCG plans to minimise the impact of increased patient demand on local Accident and Emergency services over the Easter weekend by providing enhanced services. The practice planned to provide appointments between 9am and 12pm on Easter Saturday.

Tackling inequity and promoting equality

The practice had analysed its patient list in terms of population, culture and ethnicity and the overwhelming majority of patients were white British. The practice did not have patients who were identified as homeless or from a travelling population. There were procedures and systems in place to support patients with these specific needs should they be registered at the practice.

Patients who needed extra support because of their complex needs were allocated a longer time for their appointments. We saw specific tailored care plans to meet their needs for patients with learning disabilities and for those affected by dementia as well as those with long term medical conditions. We saw that all patients who had learning disabilities had been contacted and invited to attend the practice for their annual health reviews. At the time of our inspection 63% of patients had attended reviews and the practice was working proactively to ensure that the remaining reviews were completed.

Access to the service

GP appointments were available between 9am and 11.50am, and between 2pm and 6.20pm. Nurse led appointments and clinics were also available with ante-natal clinics held on alternate Thursdays and childhood immunisations clinics held every Wednesday morning. Routine appointments could be pre-booked up to three weeks in advance in person, by telephone or online. Home visits and telephone consultations are available daily as required. 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. Home visits were made to a local care homes as required. These visits were carried out by the duty GP and used to review patient's medication and any changes in their medical conditions.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Four of the 24 patients who completed CQC comment cards said that they had difficulties in accessing appointments or had to wait a long time to see the GP. Other patients told us that they were satisfied with the appointments system.

We reviewed comments made about the practice on the NHS Choices website and the national GP survey data (2013). We saw that 79% of patients said that it was easy to get an appointment and 90% of patients said that their appointment was at a convenient time. 48% of patients said that it was easy to get through to the practice by telephone. We discussed these ratings with the GP and practice manager and they told us that access to appointments had been affected by the resignation of two GP partners within 12 months. They told us about the

Good

Are services responsive to people's needs?

(for example, to feedback?)

changes made to improve access. These included deploying extra staff to answer telephones at busier times, and there were plans to make changes to the appointment system from 1st April 2015. All appointments on Mondays would be changed to book on day and one third of all appointments for other days could be booked in advance so as to free up more on the day appointments.

The GP and practice manager told us that a salaried GP had been employed and a nurse practitioner was due to commence employment within the next few weeks. The practice also monitored the number of appointments lost through patients failing to attend and cancel. These equated to approximately 12.5 hours lost in February 2015. This information was displayed in the patient waiting areas to remind patients to cancel appointments should they be unable to attend. Reception and administrative staff also showed us that they regularly contacted patients by text message, to remind them of scheduled appointments in an attempt to reduce the number of missed appointments.

The practice is located in a two storey building with consulting rooms situated on the both floors. Access to the practice was accessible to patients by means of a ramp if required. Staff told us that patients with mobility difficulties were offered consultations in rooms situated on the ground floor. We saw that GPs and nurses met patients in the waiting area and escorted them to consulting rooms so that they could assess any needs. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Disabled access toilet and baby changing facilities were available. A hearing loop was available for patients with hearing difficulties.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person (the practice manager) who handled all complaints in the practice. There was clear written information available to patients, which described the complaints process and how they could make complaints and raise concerns. This information included details of the timelines for investigating and responding to them. This information was available within the practice waiting area. Patients were advised what they could do if they remained dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman, a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

GPs, nurses and administrative told us that the practice had an open culture where they felt safe and able to raise concerns. They told us learning from complaints and when things went wrong was shared through meetings and that there were mechanisms in place for making improvements as needed to help minimise a reoccurrence. From complaints records and the minutes of staff meetings we saw that complaints were discussed as was learning from incidents and improving patients' experiences. We saw that an analysis of complaints carried out by the practice manager highlighted trends in patient dissatisfaction such as issues with repeat prescriptions or access to appointments. We saw evidence of changes in practice and staff learning as a result of complaints received. For example, following concerns raised about access to appointments and difficulties that patients expressed about telephone access extra staff were deployed to answer telephone calls during busy periods such as mornings and arrangements were in place so from 1st April 2015 that all appointments on Mondays would be available to be booked on the day.

We looked at the records for complaints that had been received by the practice within the previous 12 months. We saw that these had been investigated and responded to appropriately and in line with the practice policy and procedure for handling complaints. Patients we spoke with told us that they knew how to raise concerns and to make complaints. They said that they felt confident that their complaints would be dealt with appropriately and that the practice manager and GP were approachable.

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 and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were aware of the vision and values for the practice. The practice team shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. The practice philosophy was described in the patient information leaflet and on the practice website.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews, audits and listening to staff and patients.

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. A number of policies and procedures required review and the practice manager was in the process of doing this. Staff told us that they were aware of their roles and responsibilities within the team. The majority of staff had lead roles, these included infection control, palliative care and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working and in practice. The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. We saw examples of completed clinical audit cycles demonstrating that the practice was reviewing and evaluating the care and treatment patients received.

From a review of records including minutes from staff meetings, appraisals, complaints and significant event recording we saw that information was regularly reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments.

Leadership, openness and transparency

All staff we spoke with told us that GPs and the practice management team were approachable. They told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held weekly meetings and met more frequently where required to discuss any issues or changes within the practice.

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

The practice had a newly set up Patient Participation Group (PPG) and the manager was considering setting up a virtual group for patients who were unable to participate fully in meetings but who may wish to contribute by email. A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. At the time of our inspection the group was not active in that they had not held any meetings. The practice regularly assessed patient feedback through the Friend and Family test, which they reviewed each month and identified any areas for improvement in how the practice was managed. The practice issued a regular newsletter to inform patients about changes affecting the practice such as the employment of new staff and changes to appointments system.

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

Are services well-led?

Good

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

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality patient care. We saw that there were improvements needed to ensure that learning from incidents, significant and serious events and complaints took place.

Records showed that clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected time for learning and personal development.