Eastwood Group Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 Eastwood Group Practice on 22 July 2015. Overall the practice is rated as good.

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

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. Significant events were recorded however these records were brief and dos not include details who was responsible for actions and learning. Reviews were not recorded to demonstrate that learning had been embedded into practice.
- There were robust arrangements for managing medicines and minimising the risks of infections.
- The practice had robust systems for safeguarding adults and children and sharing information with other agencies as appropriate.
- Staff were recruited with all the appropriate pre-employment checks carried out. The induction for newly employed staff did not include details of the length of induction or specifics for what the induction covered. There were enough staff employed to keep patients safe.
- There were appropriate measures in place for assessing risks to staff and patients' health and safety, including a detailed business continuity plan to deal with any untoward event that may impact on the delivery of service.

Summary of findings

- Patients' needs were assessed and care was planned and delivered following best practice guidance and referrals to secondary care services were made in a timely way.
- Policies and procedures were written with reference to appropriate guidance. The practice worked with other health and social care providers to ensure that patients received continuity of care and treatment.
- Patients said they were treated with empathy, compassion, dignity and respect. They said that they were listened to and involved in making decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. Written responses to some complaints we saw could be interpreted as defensive in nature.
- Appointments were flexible to meet the needs of all population groups. The practice was accessible and GPs provided a flexible service to patients in their homes as needed.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff were supported by management.
- The practice sought feedback from staff and patients. They demonstrated learning from listening to staff, patients and other stakeholders.

We saw one area of outstanding practice:

- One of the GPs carried out twice weekly scheduled visits to patients in the five local care homes. This helped to effectively monitor and treat patients thereby identifying and treating changes in patients' health. The managers of care homes we spoke with told us that these visits benefited both patients and their relatives. One care home manager told us that these visits had reduced the need for unscheduled home visits, increased confidence in the practice and allowed patients relatives to meet with and discuss any concerns or changes in treatment with the GP. The practice was monitoring the effectiveness and benefits of these visits. Initial findings suggested that the planned twice weekly visits had resulted in a reduction in requests for unscheduled home visits and the numbers of unplanned hospital admissions indicating that patients' needs were being met effectively.

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

Importantly the provider should:

- Review the systems for recording significant and other safety events so that they describe in detail the analysis of the event, the person(s) responsible for completing actions; and a record of when these actions have been completed.
- Ensure that all new staff undertake a period of induction when the start work at the practice.
- Ensure that complaints are responded to in line with the practice policies and procedures.

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. Safety alerts and serious incidents were acted on and learned from to improve patient safety. Significant events and safety incidents were investigated. Although records were kept these were brief and would benefit from further detail of the analysis of the incident, what went wrong and who was responsible for any actions required.

The premises and equipment was suitable and safe, and risks to patient and staff safety were identified and well managed. The practice was clean and there were effective infection control procedures in place. Medicines were stored, handled and disposed of safely. Staff were recruited robustly and employed in appropriate numbers and trained to treat patients safely. A staff induction checklist was in place for newly employed staff. This did not specify the duration of the induction period or the specific areas covered.

Are services effective?

Good

The practice is rated as good for providing effective services. Nationally published data made available to us including comparisons to other GP surgeries within the area showed that most patient outcomes were similar in relation to assessing and treating patients with long term conditions, vaccination and screening programmes. Treatment was planned and delivered in line with local and national guidance for GP practices. The practice staff worked with multidisciplinary teams including community nurses, health visitors and social workers to improve outcomes for patients and ensure that they received coordinated care and support as needed.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the National GP Patient Survey from 2014/15, Friend and Family Test and NHS Choices showed that patients rated the practice in line with or higher than others in the area for several aspects of care. Patients expressed satisfaction for how they were treated by GPs and nurses, their involvement in their care and treatment, and being listened to. Patients we spoke with during the inspection said they were treated with dignity and respect and they were involved in decisions about their care and treatment. The practice considered the needs of patients and their families when patients were receiving palliative care and nearing their end of their life and supported families following bereavements.

Summary of findings

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 monitored and changed access to services to meet these needs. The appointments system was flexible and extended hours were available on Monday and Wednesday evenings at their Belfairs Branch and Thursday evenings at their Rayleigh Road Branch. Home visits were available all day for those patients who were unable to attend the practice. Twice weekly visits were made to review and treat patients in each of the five local care homes where patients resided. The practice premises were purpose built and easily accessible to patients including those with physical disabilities or impairment. Improvements were needed in the way in which complaints were responded to.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy to meet the individual needs of patients taking into consideration the health care needs of the local population. The practice sought and acted on the views of patients and staff to make improvements to the services provided. There was a clear leadership structure and staff felt supported by management. Learning and improvement was promoted through a system of forward planning, audits and reviews.

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. All patients over the age of 75 years had a named accountable GP who was responsible for their care and treatment and a full range of screening and vaccinations were available. The practice identified patients who were at risk of avoidable unplanned hospital admissions and planned care in conjunction with other health and social professionals to prevent unplanned admissions. Regular multidisciplinary team meetings were held with other health and social care professionals to support patients and ensure that they received coordinated care and treatment.

The practice demonstrated proactive and effective systems for monitoring and treating patients over the age of 75 years. They had reviewed their procedures for carrying out home visits and increased the numbers of home visits available each day. These visits could be requested throughout the day and were carried out by the duty GP.

The practice carried out twice weekly visits to the five local care homes where their patients resided. The managers of four of these care homes were contacted by us and they reported that these visits benefited both patients and their relatives. Managers of these care homes told us that these scheduled visits helped to identify any changes in patients' health and manage these effectively. They also told us that patients' relatives found the visits beneficial as they could plan to meet with the GP and discuss treatments or any concerns they had. The practice was monitoring the effectiveness of these visits and told us that they had reduced the number of requests for unscheduled home visits thus indicating that patients' needs were being met. The practice had also reviewed the impact of these visits on unplanned hospital admissions for patients who lived in care homes and found that the weekly visits to patients had reduced these numbers.

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 had regular health and medication reviews. The practice offered a number of clinics including clinics for diabetes, asthma, Chronic Obstructive Pulmonary Disease, heart disease, peripheral vascular disease and some recurrent eye conditions. Comparative data showed that the practice performed above or in line with other practices both locally and nationally for reviewing and treating patients with long term

Summary of findings

health conditions. The practice proactively encouraged patients to attend appointments for routine screening so as to help early detection and diagnosis of a number of long term conditions including heart disease, diabetes and respiratory illnesses. When patients required referral to specialist services, including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments were flexible and walk-in services were available each day. Ante-natal and post-natal checks were available. The practice monitored the physical and developmental progress of babies and young children. Appointments for children were made available outside of school hours wherever possible and urgent same day appointments were available for children under 5 years. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect. Staff were trained and aware of their responsibilities to recognise and report concerns about the safety and welfare of children and young people.

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). Appointments were flexible with telephone consultations, pre-booked and on the day appointments. Extended hours were available three evenings a week and morning and appointments are available fro 8.30am each day. NHS health checks for patients aged between 40 and 75 years were available and promoted within the practice and on their website. Nurse led clinics were provided for well patient health checks.

The practice promoted good health and advice on disease prevention through health promotion clinics and information for patients around healthy lifestyle choices.

Summary of findings

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. Staff were trained to identify and respond to the needs of patients who may be vulnerable, including those who lacked capacity to make some decisions in relation to their care and treatment. The practice recognised the needs of people who were vulnerable such those with depression, alcohol or substance misuse issues, people with mental health conditions and those with learning disabilities. The practice had a dedicated clinical lead for learning disabilities and patients' health was monitored through annual health checks.

The practice worked with other health and social care professionals and held regular multidisciplinary meetings to discuss, review and plan for the health care needs of vulnerable patients. Staff were trained and understood their responsibilities to report concerns about the welfare of patients to the appropriate agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia). GPs and practice nurses were trained and skilled in screening to help early detection and diagnosis of mental health conditions such as depression and dementia. People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams to support people experiencing poor mental health including those with dementia. The practice had proactive processes for dementia screening and referrals were made to specialist services as required. Patients who were diagnosed with dementia had holistic based care plans and the practice worked closely with the local dementia nurse team to help ensure that patients received appropriate care and treatment according to their changing needs.

The practice had suitable processes for referring patients to appropriate services such as psychiatry and counselling, including The Improving Access to Psychological Therapies (IAPT) and referrals to Child and Adolescent Mental Health Services (CAMHS) as required.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by reviewing data available from NHS Choices and the National GP Patient Survey results from 2014/15. Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution among patients in order to obtain their views about the practice and the service they received. We spoke with four patients on the day of the inspection.

The results from the National GP Patient Survey 2014/15 and NHS Choices indicated that the majority of patients were happy with the practice and their involvement in making decisions about their treatment. The practice performed lower than other GP practices locally and nationally for patient satisfaction in relation to making appointments, getting through to the practice by telephone and the ability to see their preferred GP.

The results of the NHS Friends and Family Test between March and June 2015 showed that all patients who responded said that they were likely or extremely likely to recommend the practice to family and friends.

We received 10 completed 'Tell us about your care' comment cards. All of the patients who completed these expressed satisfaction with the care and treatments and service they received. Two of the 10 reported some difficulties in accessing appointments.

We also spoke with four patients on the day of our inspection, two of whom were involved with the practice Patient Participation Group (PPG). A PPG is made up of a group of patient volunteers and members of a GP practice team. Patients told us that they were happy with the service and treatments they received. They said that they could access appointments that suited them and that they were treated with kindness and respect.

Areas for improvement

Action the service SHOULD take to improve

- Review the systems for recording significant and other safety events so that they describe in detail the analysis of the event, the person(s) responsible for completing actions; and a record of when these actions have been completed.
- Ensure that all new staff undertake a period of induction when the start work at the practice.
- Ensure that complaints are responded to in line with the practice policies and procedures.

Outstanding practice

- One of the GPs carried out twice weekly scheduled visits to patients in the five local care homes. This helped to effectively monitor and treat patients thereby identifying and treating changes in patients' health. The managers of care homes we spoke with told us that these visits benefited both patients and their relatives. One care home manager told us that these visits had reduced the need for unscheduled home visits, increased confidence in the practice and allowed patients relatives to meet with and discuss any concerns or changes in treatment with the GP. The practice was monitoring the effectiveness and benefits of these visits. Initial findings suggested that the planned twice weekly visits had resulted in a reduction in requests for unscheduled home visits and the numbers of unplanned hospital admissions indicating that patients' needs were being met effectively.

Eastwood Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a Care Quality Commission inspector and a Care Quality Commission GP specialist advisor.

Background to Eastwood Group Practice

Eastwood Group Practice is located in a residential area of Leigh on Sea, Essex. The practice has been established for over 40 years and provides services for approximately 10,000 patients living within the Leigh, Eastwood and Belfairs area. The practice holds a General Medical Services (GMS) contract and provides GP services commissioned by NHS England and Southend Clinical Commissioning Group. A PMS contract is one negotiated between NHS England and the practice where elements of the contract such as opening times are negotiated and agreed locally.

The practice has two branch surgeries, in addition to the main surgery, and located within half a mile of each other within the Eastwood, Leigh and Belfairs area. Patients may visit any of the surgeries and can express their preference when they register with the practice.

The practice population is slightly lower than the national average for younger people and children under four years, and for those of working age and those recently retired, and significantly higher for older people aged over 75 years. Economic deprivation levels affecting children, older people and unemployment were lower than the practice average across England. Life expectancy for men and women are slightly higher than the national averages. The practice patient list has a higher than national average for long standing health conditions and lower disability allowance claimants. The practice has almost twice the national average of patients living in care homes.

The practice is managed by four GP partners who hold financial and managerial responsibility for the practice. The practice employs five salaried GPs. There are four female and five male GPs employed. The practice also employs one advanced nurse practitioner, three practice nurses and three health care assistants. A practice manager and assistant practice manager are supported by a branch manager for each branch surgery and team of administrative, secretarial and reception staff.

The practice is open between 8am and 6.30pm on weekdays. The practice provides extended hours when it is open until 9pm on Mondays and 8.30pm on Wednesday and Thursday evenings.

The practice has opted out of providing GP out of hours services. Unscheduled out-of-hours care is provided by the NHS 111 service and patients who contact the surgery outside of opening hours are provided with information on how to contact the service. This information is also available on the practice website.

Why we carried out this inspection

We inspected Eastwood Group Practice 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

Detailed findings

whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. 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. We carried out an announced visit on 22 July 2015. During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager, reception and administrative staff. We reviewed policies, procedures and other documents in relation to the management and day-to-day running of the practice. We spoke with patients who used the service. We talked with carers and family members. We reviewed comment cards, NHS Choices and National GP Patient Survey 2014/15 results 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 had policies and procedures for reporting and responding to accidents, incidents and significant events. Staff we spoke with told us that they were aware of the procedures for reporting and responding to incidents and significant events. They told us that they were supported to raise concerns and that the procedures within the practice worked well.

There were systems for the receipt and sharing of safety alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA) alerts. These alerts have safety and risk information regarding medication and equipment often resulting in the review of patients prescribed medicines and/or the withdrawal of medication from use in certain patients where potential side effects or risks are indicated.

The practice manager told us that MHRA and other relevant alerts were forwarded to her deputy who would then cascade to the relevant practice staff either for information, or for action, for example to identify any patient or equipment which may be affected. When the alert had clinical implications, advice was always sought from a GP prior to sending it to other practice staff. Paper copies of the alerts were maintained for reference. There was no record of any actions which had been taken to ensure that the alert had been actioned fully and appropriately. There was no written procedure for the management of safety alerts at the time of the visit, although staff were fully aware of the process. The practice manager produced a written procedure before the inspection ended.

Learning and improvement from safety incidents

Staff we spoke with said that the practice had an open and 'no blame' culture and they would be confident to report any significant or untoward event to their line manager. We saw that reporting forms were available on the computerised system and hard copies were also available and staff were aware of where to find these. We reviewed the significant events recorded and investigated within the previous six months. We saw that the description of the event, discussion and learning was recorded. Records included an analysis of what went wrong, and the actions undertaken to minimise any reoccurrence. The information was brief within the reports and records we looked at did not include a detailed analysis of any contributory factors or detail of who was undertaking any defined action, the predicted timescale for completion, and the date that all actions have been fully completed.

Through discussions with the practice manager and a review of records we saw that significant events were discussed at dedicated six monthly meetings and notes were produced. This enabled the practice to identify any trends that arose so they could address any themes effectively. If any incident required wider discussion with other staff more urgently, this was discussed at more regularly held clinical meetings. We saw evidence of learning from when things went wrong. For example following a delay in a patient referral the practice had reviewed its systems for sending referral letters and these were sent directly from each branch rather than being sent to the main branch. This reduced the time in the referral being made and minimise the risk of lost or misplaced referral.

Reliable safety systems and processes including safeguarding

The practice had suitable policies and procedures in place to identify risks to vulnerable children, young people and adults. All staff at the practice had undertaken appropriate safeguarding children and adults training. The practice had a dedicated lead GP who had oversight of the safeguarding arrangements. Staff we spoke with were aware of the practice procedures for protecting vulnerable patients. They knew how to identify signs of potential abuse or neglect in children, older and vulnerable patients and who to report these concerns to. Staff were aware of their responsibilities for reporting concerns externally such as referring concerns to the local safeguarding team if appropriate.

Information about vulnerable patients was shared with staff appropriately. There was an alert system to highlight vulnerable patients on the practice's electronic records. GPs were using the required codes in electronic records to ensure risks to vulnerable adults, and children and young people who were looked after (under the care of the local authority/in foster care) or on child protection plans were clearly flagged and reviewed. Records showed that information was shared with appropriate agencies including local social services, the police and health visitors

as appropriate. Appropriate checks were made upon receipt of any request for information to ensure this was necessary and that the person making the request could confirm their identity and role.

The practice had a chaperone policy. A notice regarding access to a chaperone was clearly visible on the reception desk in the waiting room. (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). Chaperone duties were carried out by administrative and reception staff and approximately 75% of the administration team had received training to undertake this role. All of these staff had an appropriate Disclosure and Barring Service (DBS) check in place. The Disclosure and Barring Service (DBS) helps employers prevent unsuitable people from working with vulnerable groups, including children. The staff we spoke with had a good understanding of their responsibilities when acting as chaperones.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were written procedures in place for the receipt, handling and storage of temperature sensitive medicines such as vaccines to ensure that medicines remained effective and suitable for use. The temperatures of fridges used to store medicines were monitored daily, and this incorporated the minimum and maximum temperature achieved within a 24 hour period. This helps to identify any issues with the storage of medicines such as vaccines and other medicines which require cold storage to ensure that they do not exceed those recommended by the medicine manufacturer. The refrigerator also had an internal data logger as a back-up system to monitor the temperature and this was reviewed regularly. From records we saw that the manually recorded temperature of this fridge regularly reached just above 8 ˚C, which is at the higher end of the recommended storage temperatures (2 ˚C to 8 ˚C). There were no records to demonstrate what action had been taken to address this issue and staff we spoke with said that they had not reported the elevated temperatures.

The practice had recently purchased a portable vaccine refrigerator to assist in delivering the influenza vaccine to 80 housebound patients, and care home residents. As a new development this had not been incorporated into the practice cold chain policy. However, when this was brought to the attention of the practice manager, the policy was immediately updated and there were plans to advise staff of the update.

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

Systems were in place to check medicines every three months to ensure they were within their expiry date and suitable for use and we confirmed this via a random check on medicines. Expired and unwanted medicines were disposed of in line with the practice medicines management policies.

Prescriptions pads were securely stored and logged. Robust systems were in place for the management of scripts for a pilot service being undertaken to provide remote on line access to consultations for minor illnesses.

The practice had robust systems for monitoring patients who were prescribed high risk medicines. GPs we spoke with were aware of the local shared care arrangements and their responsibilities. We saw that patients who were prescribed these medicines were reviewed regularly and information from secondary care services was shared, received and acted on to ensure that patients received these medicines safely.

Cleanliness & Infection Control

The practice had policies and procedures in place to protect patients and staff against the risk of infections. These included procedures for dealing with bodily fluids, handling and disposing of clinical waste, dealing with needle stick injuries and managing risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings). The practice had an identified infection control lead nurse who had undertaken appropriate training, and supported the practice manager to oversee infection control procedures within the practice.

The practice was exceptionally clean and tidy, and cupboards were maintained in an orderly manner and free of any visible stains or unwanted equipment. Hand sanitising gels were available for patient use. Hand washing sinks with liquid soap, sanitising gel and paper towel

dispensers were available in treatment rooms and toilet facilities. We saw evidence to confirm that patient disposable privacy curtains were changed on a regular basis. We saw that the practice had arrangements to segregate and safely store clinical waste including disposable instruments and needles at the point of generation. A well maintained and secure outdoor waste storage area was available, and this ensured that the level of waste kept inside the premises was kept to a minimum.

Staff were provided with appropriate personal protective equipment (PPE) including disposable gloves and aprons. We saw readily accessible stocks of PPE within each clinical room. Spillage kits were available for cleaning and disposing of body fluids and staff we spoke with were aware of where to locate these when needed. Records showed that all clinical 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. Reception staff were also given the opportunity to have this vaccination if they so wished.

The practice carried out routine surgical procedures and we saw that audits were carried out to identify and minimise the risks of infections.

We saw there were cleaning schedules in place for cleaning tasks in both general and clinical areas. Records were kept to show when cleaning had been carried out and these were audited by the contracted cleaning company. The practice had their own internal arrangements for monitoring the infection control procedures and three monthly infection control audits were carried out to test the effectiveness of the procedures in place to protect staff and patients against the risks of infection. Copies of the audits were seen during the visit. Following audits action plans were developed reviewed and updated to show that any areas for improvement were dealt with promptly.

A validated external provider had been commissioned by the practice in 2014 to undertake a comprehensive infection control audit as an additional assurance of their compliance. This had been positive and the few recommendations that resulted from the audit had been fully actioned by the practice. The company also provided on site infection control training including hand washing for practice staff.

Records showed that all staff had infection prevention and control training, and in addition to the training provided by the external company, online training had been completed and documented for staff.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of diagnostic and screening procedures such as blood tests, respiratory, diabetes and well person procedures. The practice maintained a full inventory of the equipment across the three sites. Records we viewed showed that all equipment was tested and maintained annually. All portable electrical equipment was routinely tested. All diagnostic equipment such as weighing scales, spirometer, thermometers, ear syringe and the fridge thermometer were calibrated in line with the manufacturer's instructions to ensure that this equipment was fit for use. Through discussion with staff we were informed that equipment was replaced as needed. The practice had arrangements in place with the local hospital for the repair of any broken medical equipment, but there had not been a need to access this service to date.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. We reviewed five staff records for staff including GPs, nurses and administrative staff and found that these procedures had been followed. Appropriate checks including proof of identification, employment references and security checks through the Disclosure and Barring Service (DBS) had been carried out for all new staff. These checks helped to ensure that staff employed were suitable to work with vulnerable people. Pre-employment interviews had been carried out and checks made to ensure that GPs and nurses had appropriate qualifications and effective registration with the appropriate professional body, such as the Nursing and Midwifery Council (NMC) for nurses and the General Medical Council (GMC) for GPs. Inductions were in place for new staff so that they could familiarise themselves with their roles and responsibilities.

There were detailed induction packs for GPs including locum GPs. There was an induction checklist for all other

Good

Are services safe?

staff. These did not describe the content or duration of the induction period. An induction is a process by which new staff can familiarise themselves with the practice policies, procedures and ways of working.

There were arrangements for planning and monitoring the number of staff and mix of staff (including the availability of a female GP) needed to meet patients' needs. There was a staff rota in place and staffing levels were reviewed to ensure that actual staffing levels and skill mix were in line with planned staffing requirements. As the practice covered three sites, this afforded some flexibility with planning and staff could re-locate if required. The practice had arrangements for providing staff cover in the event of unplanned absence due to illness and planned leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring Safety & Responding to Risk

The practice had robust arrangements for identifying and managing risks to staff and patients. There was a detailed health and safety policy, which staff were aware of. Risks were identified through a variety of assessments, which covered fire safety, legionella, and untoward issues which may impact on the running of the practice. These assessments were reviewed regularly to ensure that the practice environment, equipment and staff practices were safe.

The practice had an extensive range of policies and procedures for recognising and responding to risks to patients. Regular meetings took place with community based health care staff and other agencies to ensure more vulnerable patients, including those with palliative care needs, were reviewed in order to address their individual needs and avoid unnecessary hospital admissions. Staff we spoke with were aware of the systems in place and could contribute to identifying those vulnerable patients where concerns might exist.

The practice manager had developed a robust system of reminder alerts to ensure that any reviews of audits, risk assessments and training were done at the right time.

Arrangements to deal with emergencies and major incidents

The practice had policies and procedures in place to manage medical emergencies. Records showed that all staff had received training in basic life support. Emergency medicines and equipment were available including access to oxygen. The health care assistant checked emergency equipment and medicines each month and these checks were recorded.

During our visit, we saw the practice respond to a medical emergency. The practice staff responded appropriately in delivering the immediate and necessary treatment to deal with the presenting medical symptoms and called the ambulance service. This demonstrated the practice's ability in dealing with medical emergencies in an effective and prompt manner to ensure patient welfare.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as loss of power, adverse weather conditions, staff shortages or other circumstances that may affect access to the building or a disruption of the service. The plan described staff roles and responsibilities in the event of any untoward event. Staff we spoke with were aware of the plan and what action to take should the need arise. We saw that the plan contained relevant details and contact numbers to assist staff. There was access to the plan outside of working hours in case of any untoward event preventing access to the premises. The practice held a mobile telephone at each site as a contingency in case of telephone breakdown, and we saw evidence that this was proactively managed as the phones were kept charged and regularly rung to ensure they were still in full working order.

There were robust arrangements for assessing and managing any risks of fire within the practice. Weekly fire alarm tests were undertaken and evacuations drill had been carried out. Staff were trained in fire safety procedures. An external fire assessment had been undertaken following a recent refurbishment of the premises, and this company had provided fire training for all staff. This had been reinforced by further on line training. Records showed that fire safety equipment including extinguishers and alarms were tested and serviced regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patient care and treatment was delivered in line with recognised best practice standards and guidelines including the National Institute for Health and Care Excellence (NICE), Clinical Commissioning Group guidelines and policies. Staff told us that information and any changes in legislation or national guidelines were shared during regular clinical staff meetings. Records we viewed confirmed this. New patients were offered health checks when they joined the practice and staff proactively contacted patients where appropriate to attend for regular health checks and reviews.

GPs had lead roles for a number of areas including palliative care, mental health, care of older people and dementia, family planning and minor surgery. They served as a source of expertise for colleagues in the practice and were responsible for ensuring new developments or specific clinical issues were discussed at the relevant practice meetings. There were a number of clinics held at the practice including those for asthma and chronic obstructive airways disease, family planning, minor surgery and diabetes. The nurse practitioner and practice nurses supported this work through nurse led clinics which allowed GPs to focus on patients with more complex healthcare needs.

All GPs we spoke with used national standards guidance for patients with suspected cancers to be referred and seen within two weeks. We saw that regular discussions were held between GPs to discuss patient care and pathways for medical conditions such as diabetes respiratory and cardiac conditions to help ensure that appropriate referrals were made to secondary care services where appropriate.

Staff told us that information relating to patients who accessed the out-of-hours services and patients' test results were reviewed by GPs on a daily basis. We saw that when patients were discharged from hospital, their discharge summary letters were reviewed by administrative staff who made changes to prescriptions. These were then sent to the patient's GP to review and agree the changes.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, summarising patients' records, managing child and adult safeguarding alerts and medicines management. Information was shared widely with staff and other healthcare professionals.

The practice participated in a number of enhanced services commissioned from the Clinical Commissioning Group (CCG), Public Health and NHS England. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract to improve outcomes for patients). The practice kept registers of patients with learning disabilities, those receiving palliative care and patients who were identified as vulnerable or at risk of unplanned hospital admissions. Patients had care plans and the practice held regular multidisciplinary meetings which were well attended by external professionals such as the community nursing team to help ensure that patients were treated and supported appropriately according to their assessed needs. We found that the practice was performing in line with local and national targets for the uptake of all childhood vaccinations and immunisations, flu vaccinations and women's cervical screening.

Data we reviewed showed that the practice's performance in assessing and treating the majority of patients with long term conditions such as diabetes, asthma, chronic respiratory diseases and heart disease were in line with or above that the local Clinical Commissioning Group (CCG) and national averages

The practice had a system in place for carrying out clinical audits, 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. We saw that a number of clinical audits had been carried out within the last two years including one which reviewed cervical smears to identify any variances and the number of inadequate samples. Learning from this audit was shared with clinicians to help improve sample taking and reduce the risks of these needing to be taken again. Another audit was carried to monitor the treatment of patients with Chronic Obstructive Pulmonary Disease (COPD). The practice reviewed its procedures for monitoring patients with COPD and ensuring that they received the season flu

vaccine. The audit showed a steady increase in the number of patients who had pulmonary function tests (spirometry) and those who had received the flu vaccine between March 2014 and January 2015. The practice felt that this had reduced the number of unplanned hospital admissions; however data was not yet available to support this.

The practice protocol for repeat prescribing was in line with national guidance and staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice was amongst the best in the CCG area for some medicine prescribing such as use of frontline antibiotics and use of non-steroidal anti-inflammatory medicines NSAIDs (used to treat inflammatory conditions such as arthritis).

Effective staffing

The practice employed staff who were suitably skilled and qualified to perform their roles. All GPs were up to date with their yearly continuing professional development requirements. (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 clinical and non-clinical staff had clearly defined roles within the practice and were able to demonstrate that they were trained to fulfil these duties. All staff undertook annual appraisals of their performance from which learning and development needs were identified. Records viewed showed that staff had individual personal development plans in place. Staff we spoke with were positive about the peer support arrangements and working relationships between all members of staff within the practice. The practice also had systems in place for identifying and managing staff performance and providing support and further training to assist staff should they fail to meet expected standards.

Working with colleagues and other services

The practice worked proactively with other service providers, including social services, the local hospital trust and community services to meet patients' needs and support patients with complex needs. They worked closely with the five local care homes where they had patients. The managers of these homes told us that information was shared effectively and that the practice worked well with them to assess, treat and monitor patient's health care needs.

There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out–of-hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to which the relevant community health and social care professionals were invited to review and plan care and treatment for patients such as those with life limiting illnesses and vulnerable patients. The out-of-hour's service had access to appropriate information to assist doctors to treat patients as needed when the practice was closed. The practice engaged with the local Clinical Commissioning Group for support and advice on issues relating to primary medical services.

Information Sharing

The practice had systems to share information with staff, patients and other healthcare providers. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice used several electronic systems to communicate with other providers. For example, there were facilities for sharing patient records between GP practices when a patient registered or deregistered. The community nursing team and health visitors had access to the patient records where patients had consented to the sharing of their medical information. Electronic systems were also in place for making referrals to secondary care services such as specialist consultants. Staff reported that the systems were easy to use.

The practice had ensured the electronic Summary Care Records were completed and accessible on line. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an

Good

Are services effective?

(for example, treatment is effective)

emergency or outside of normal hours. Information about the sharing of patient information was available on the practice website and in written leaflets which were readily available.

Consent to care and treatment

The practice had policies and procedures in place for obtaining a patient's consent to care and treatment where patients were able to give this. The policy covered obtaining and documenting consent for specific interventions such as minor surgical procedures and vaccinations. GPs and nurses we spoke with had a clear understanding of these procedures and told us that they obtained patient's consent before carrying out physical examinations or providing treatments. We saw that where a patient's verbal consent was given this was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent procedures included information about people's right to withdraw consent.

Staff we spoke with understood the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties to meet the requirements of these legislations when treating patients. 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. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they and/or their carers were involved in agreeing, where they were able to do so. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment). Patients we spoke with confirmed that their treatment, options available, risks and benefits had been explained to them in a way that they could understand. They told us that their consent to treatment was sought before the treatment commenced.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room with dedicated patient information boards. These included information to promote good physical and mental health and lifestyle choices including advice on diet, smoking cessation, alcohol consumption and substance misuse. There was information available about the local and national help, support and advice services. Information about the range of immunisation and vaccination programmes for children and adults, including Mumps, Measles and Rubella (MMR), shingles and a range of travel vaccinations were well signposted throughout the practice and on the website.

The practice offered a full range of health checks. All newly registered patients were offered routine medical check-up appointments. 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. Data we viewed for 2013/14 showed that the practice performed at or above the local and national averages for the uptake of standard childhood immunisations, seasonal flu vaccinations, cervical screening (smear tests) and annual health checks for patients with one or more long-term health condition such as diabetes and respiratory diseases and those with learning disabilities.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Each of the four patients we spoke with during our inspection and the 10 patients who completed comment cards said that all staff were caring and that staff listened to them and took their views and concerns into consideration. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014/14 National GP Patient Survey. 86% of patients who responded said that the receptionists were helpful. 82% said the last GP who they saw were good at treating them with care and concern. These results were similar to GP practices both locally and nationally.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting and in treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Reception staff dealing with telephone calls were located separately from the reception desk and this helped to maintain privacy and confidentiality of conversations.

Staff told us that 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 who would investigate.

Care planning and involvement in decisions about care and treatment

Four patients we spoke with on the day of our inspection told us that they felt they were listened to and involved in discussions about their care and treatment. They told us told us that health issues were discussed in a way that they could understand and they felt listened. Patients told us that they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 10 comment cards we received was also positive.

We reviewed information from the 2014/15 National GP Patient Survey. 86% of patients who responded to the survey said that GPs and nurses were involving them in decisions about their care. 88% of patients felt that GPs and nurses were good at listening to them. These results were similar to GP practices both locally and nationally.

The practice had considered the needs of the local population group and had identified patients from ethnic minorities and those whose first language was not English. Staff told us that language interpretation services were available and they knew how to access these. They also told us that they actively engaged with patients from the travelling communities in the area to improve their access to the practice. Discrimination was avoided when making care and treatment decisions and GPs said that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Patient/carer support to cope emotionally with care and treatment

Patients who we spoke with during the inspection told us that staff were caring and that they offered emotional support as needed. We saw that the practice worked proactively with other health and social care providers including local hospice services to enable patients who wished to remain living in their homes when their health deteriorated. We saw that patients receiving palliative care had care plans, which were shared with relevant health care providers, including the out-of-hours service to ensure that patients received appropriate care as they approached their end of life. The practice had procedures for supporting bereaved families. Where families experienced bereavement their GP contacted them by telephone and appointments or home visits were arranged as needed.

The practice had policies and procedures in place for identifying and supporting patients who voluntarily spent time looking after friends, relatives, partners or others due to illness or disability. Patients who were carers for others were identified at registration and provided with information to ensure they understood the various avenues of support available to them. Information in the patient waiting room, told patients how to access a number of support groups and organisations within the local area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to plan and deliver appropriate and responsive services. Services were provided across three sites which were located within half a mile of each other. 12% of the practice population was over 75 years, which was higher than other GP practices locally. The practice reviewed its appointments system to meet the needs of their population groups. The duty doctor system had been reviewed due to the increasing number of requests for home visits by people living in their own homes and those who resided in local care homes. This enabled home visits to be carried out more flexibly during mornings and afternoons as required rather than the previous arrangements whereby these visits were only conducted between morning and afternoon surgeries. We spoke with the managers from four of the care homes who provided accommodation for the practices' patients and they reported that they received a responsive service. Managers told us that GPs responded to requests for visits in a timely. They also reported that the twice weekly visits helped to ensure that patients received a good level of care and that relatives found it useful to meet with the GPs to discuss any concerns.

The practice was monitoring the benefit to patients of the twice weekly visits made to patients in local care homes. They showed us data which suggested that these visits helped GPs to quickly identify and respond changes in patients' health. The practice had monitored the number of requests from two care home for unscheduled visits before and after the introduction of the weekly visits. These showed that the number of requests for visits had been reduced from on average 35 per month to approximately 13 per month. The practice also monitored the unplanned hospital admissions for patients who lived in care homes. Between December 2013 and August 2014 of the 59 patients who died six died in hospital. Between December 2014 and August 2015 of the 80 patients who died 9 died in hospital. All patients had been reviewed by a GP within 14 days of their death and care plans and records reflected the care and treatments that patients required to support them to spend their final days in their home and to avoid unplanned admissions to hospital. This demonstrated that the practice was proactively responding to the needs of patients.

Tackling inequity and promoting equality

The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds and patients whose circumstances made them vulnerable or hindered access to services. The practice maintained registers of patients with learning and physical disabilities and those with mental health conditions. The practice offered a full range of health checks all their patients with learning disabilities and mental health conditions had annual physical checks. The practice had dedicated clinical leads for learning disabilities and dementia who worked with local health and social care professionals to provide coordinated and holistic care and treatment.

The practice had policies and procedures for promoting diversity and equality. The majority of patients at the practice spoke English as their first language. The practice had access to language translation services if required. The practice information leaflet was available in large print and a hearing loop system was available to support patients who used hearing aids and devices. The practice had considered the needs of patients with physical disabilities and those with young children. Two of the three branch locations had undergone extensive refurbishment to improve the facilities and access to these. The waiting area was large enough to accommodate patients with wheelchairs and prams, and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice as well as baby changing facilities.

Access to the service

Details about how to make, reschedule and cancel appointments was available to patients on the practice website. Appointments were available between 8am and 6.30pm with extended opening until 8pm three days each week. Appointments could be made online, in person and by telephone and could be booked up to six weeks in advance. Home visits were available each day and the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice carried out up to 10 visits daily. Patients could attend the branch of their choice and were able to choose their preferred branch when they first registered with the practice.

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 they were put through to the out-of-hours GP service.

We spoke with four patients and reviewed 10 comment cards during the inspection. Those patients we spoke with told us that they were happy the appointment system and that they could usually see or speak with their preferred GP and same day appointments for urgent treatments if needed. Three of the 10 patients who completed comment cards told us that they experienced some difficulty in accessing appointments and one said that it was sometimes difficult to get an appointment with their preferred GP.

We reviewed the data from the most recent National GP Patient Survey 2014 /15. Results of the survey showed that the practice performed lower than GP practices nationally and within the local Clinical Commissioning Group area for patient satisfaction around getting through to the practice by telephone, ease of making and convenience of appointments. For example 57% said that they found it easy to contact the practice by telephone. This was lower than the local average of 75% and national average of 74%. 39% of respondents who had a preferred GP said that they said that they usually got to see or speak with that GP. This was also lower that the local average of59% and national average of 60%. 59% of patients described their overall experience of making an appointment as good compared to the local average of 75% and national average of 74%. There were similar negative comments made by patients on the NHS Choices website about access to the service.

GPs told us that they had experienced a period of staffing shortages between 2012 and 2014 due to staff retiring and some staff absences due to ill health. The practice now had a full complement of staff and had reviewed its appointment system to offer more book on the day appointments. Patients we spoke with told us that this had helped to improve access to appointments.

The practice was proactive in reviewing access to services for patients and had secured local funding to pilot a remote consultation model over a two year period. The practice had with another local GP practice partnered with a private initiative offering telephone and online live video consultation with GPs via a mobile application. This service was in its initial stages and available to all patients at the practice. It enabled patients who commuted to London to collect prescriptions at dedicated pharmacies at Liverpool Street and Fenchurch Street rail stations. GPs told us that the initial response form patients who used the service, while not formally, analysed was very positive.

Listening and learning from concerns & 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. Patients were provided with some basic information in the patient information leaflet which described how complaints would be dealt with and responded to. This information did not describe how a patient could raise concerns or make complaints. This leaflet did not include information on how patients may escalate their concerns to the NHS England and the Health Services Ombudsman, should they remain dissatisfied with the outcome or if they felt that their complaints had not been dealt with fairly. A poster was displayed in the waiting area with this information. The practice manager told us that this information was provided in response letters sent to patients when they complained. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the four patients we spoke with said that they had previously made a complaint and that this was resolved to their satisfaction.

We looked at a sample of complaints received by the practice over the past 12 months and the practice responses to these. We saw that where complaints related to treatment that these were discussed with the GP or nurse in question as part of the investigation into the concern and that this information was included within the response. Complaints were acknowledged and responded to within the appropriate timeframe. Complaint responses were detailed and described how these were investigated and the findings. However responses we viewed did not always include an apology and the tone in which some

Good

Are services responsive to people's needs?

(for example, to feedback?)

responses were written could be perceived as defensive. GPs we spoke with assured us that this would be reviewed and a more open response provided when patients complained about the practice.

We saw that complaints were periodically analysed to identify trends or themes and these were discussed at regular practice meetings to share learning and help improve patients' experience.

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 offer high quality compassionate, patient centred care. GPs we spoke with demonstrated that they worked proactively to deliver high quality care through integrated working with other care providers including local care homes and embracing changes to meet the needs of patients, particularly those with complex needs. Staff and patient representatives we spoke with were aware of the vision and values for the practice and told us that they were involved in discussions and decisions to deliver these.

The practice was active in focusing on outcomes in primary care. The practice demonstrated a strong focus on providing an equitable service to older patients and staff were passionate about how they delivered care and treatment to this population group, including those who were living in local care homes. We saw that the practice had recognised where they could improve outcomes for patients and was making changes accordingly through work with the local Clinical Commissioning Group, conducting reviews and listening to staff and patients.

Governance Arrangements

The practice had a number of policies and procedures in place to govern its activity and these were available to staff. We looked at a sample of these policies and procedures, including those related to patient care and treatment, medicines management, infection control, staff recruitment and training, fire safety and patient confidentiality. Policies were bespoke, up to date and reflective of the management and day-to-day running of the practice.

The practice used a number of clinical and non-clinical audits and reviews to monitor and improve the services provided. Areas for improvement were identified from complaints and analysis of significant events and these were shared with staff to secure improvements. The practice reviewed and used data from local and national quality schemes such as QOF to benchmark performance. Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all practices in England and awards practices achievement points for managing some of the most common chronic diseases including diabetes, coronary heart disease and chronic obstructive pulmonary disease. The practice also reviewed its performance against local and national performance for assessing, treating and monitoring patients. We reviewed some of this data and the practice was performing in line or above the local averages for monitoring and treating patients.

There were arrangements for monitoring the treatment provided to patients who used the remote access service. Patients comments, complaints or any concerns raised were responded to and analysed to improve patients experience.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles in several areas of patient care including safeguarding adults and children, palliative care, medicines management and unplanned admission avoidance. Staff also took lead roles in infection control, fire safety and health and safety. Staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. There was good communication between clinical and non-clinical staff. The practice held a range of regular clinical and non-clinical staff meetings to discuss any issues or changes within the practice.

Seeking and acting on feedback from patients, public and staff

The practice sought and acted on feedback from patients on a regular basis. It monitored the results of the NHS Friend and Family Test, National GP Patient Survey and NHS Choices data. We saw that all patients who participated in the most recent Friend and Family Test said they would be extremely or very likely to recommend the practice to friends or family.

The practice had an active Patient Participation Group (PPG) made up of 20 patient representatives and staff from the practice who met four or five times each year. A PPG is made of practice staff and patients that are representative of the practice population who are involved in discussions and decisions about the range and quality of services provided by the practice. We spoke with two members of the PPG and they told us that the practice was open to and acted on, where possible, the suggestions made by the group. The PPG carried out patient surveys and the results

Are services well-led?

Good

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

from these were made available to patients, as they were displayed in the patient waiting area and on the practice website. The results from the most recent survey, carried out in 2014 showed that patients were satisfied with the services they received at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they were supported to actively contribute and give their feedback, comments and suggestions.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff, all of whom confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Clinical staff told us that the practice supported them to maintain their professional development through training and mentoring. All the staff we spoke with told us that the practice was very supportive of training and that they had protected time for learning and personal development. Regular clinical meetings were held where complaints, safety issues and significant events were discussed and learning shared to secure improvements.