The Fairlands Practice

Quality Report

Fairlands Medical Centre
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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 carried out an announced comprehensive inspection at The Fairlands Practice on 31 October 2014. Overall the practice is rated as good.

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

We visited the practice location at Fairlands Medical Centre, Fairlands Avenue, Worplesdon, Guildford, GU3 3NA. The Fairlands Practice also operates a branch surgery at Glaziers Lane Surgery, Glaziers Lane, Normandy, Guildford, Surrey, GU3 2DD. We did not visit the branch surgery as part of our inspection.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it relatively easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice 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.

The areas where the provider should make improvement are:

- Ensure that the lock on the refrigerator is fixed.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above the average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. 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 any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multi-disciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and

Summary of findings

meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.	
Are services well-led? The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) were active. Staff had received inductions, regular performance reviews and attended staff meetings and events.	**Good**

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Nationally reported data showed that the practice had more than the clinical commissioning group (CCG) average for people aged 65 plus and 75 plus. They had marginally fewer than the CCG average for 85 plus. The practice had a slightly than higher average deprivation score for older people than the CCG average. The practice had a small nursing home population. The life expectancy of the people using the practice was slightly higher than for the CCG area.

The practice offered a range of services which benefited older people. This included management of long-term conditions, and clinics covering a wide range of services for older patients including asthma/ chronic obstructive pulmonary disease (COPD) clinics, diabetes clinics, hypertension clinics, well woman/man checks, weight management services, smoking cessation advice, blood pressure monitoring, blood tests, ECGs, vaccinations and immunisations, as well as travel health, safe travel tips, travel vaccinations, blood tests, and x-rays.

One of the GPs within the practice was the named GP responsible for a large local care home and conducted a routine ward round there on a weekly basis. The care home had patients with very complex needs. There was a high turn-over of patients. The GP involved relatives as much as possible. The practice had employed a locum to allow extra time to undertake the care planning process. Thirty minute appointments were arranged to enable time to construct the care plans.

The practice had a lead for unplanned admissions and a frailty register based on all patients in residential care over the age of 85 years old. These patients were known to each GP.

The practice was involved with the Gold Standards Framework. This is an initiative to improve primary palliative care.

However the practice was an outlier for a regular (at least three monthly) multidisciplinary case review meeting where all patients on the palliative care register are discussed.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions.

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. 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.

The practice provided a range of services that included the management of long-term conditions, and clinics covering a wide range of services for patients include asthma/COPD clinics, diabetes clinics, hypertension clinics, weight management services, smoking cessation advice, blood pressure monitoring, blood tests, ECGs, vaccinations as well as travel health, safe travel tips, travel vaccinations, blood tests, and x-rays.

Families, children and young people

Good

The practice is rated as good for families, children and young people.

There were systems in place to identify and follow-up children living in disadvantaged circumstances and who were at risk, for example children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

A range of services were provided for families, children and young people. There were clinics covering a wide range of services for patients including asthma/COPD clinics, diabetes clinics, hypertension clinics, well woman/man checks, family planning services, weight management services, smoking cessation advice,

blood pressure monitoring, blood tests, ECGs, vaccinations and immunisations, maternity care, and child development as well as travel health, safe travel tips, travel vaccinations, blood tests, and x-rays.

One of the GPs had an interest in women's health, family planning and paediatrics. Another GP was working towards a Diploma in Sexual and Reproductive Health.

The practice had no specific lead for travellers. However, they had high users of their practice within the traveller community. The practice had success in offering immunisations. The practice was able to demonstrate a high level of knowledge of the traveller community.

The practice had a link on its website to the Fairlands and Normandy Surgeries patient survey results, minutes of the patient group meeting and action plan. The Fairlands Patient Group comprised of 76 virtual members and the report detailed the characteristic of the group. The information included; attendance, gender, ethnicity, and age. The survey was overseen by the practice manager and the patient representative and was test driven and feedback provided by another patient. The survey was made available and promoted via the practice website and at both the practice locations by the practice's reception team in hard copy throughout February 2014. The receptionists were encouraged to actively promote the survey to the practice's younger patients (under 25). The practice found that it was difficult to engage this patient group. The practice has asked GPs to target under 25s and encourage them to speak to the practice manager and or join the virtual group to provide some feedback on the services offered and their relevance to teenagers and young adults.

Working age people (including those recently retired and students)

Good

The practice is rated as good for working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice was open 8am to 6.30pm on weekdays. The reception desk opened for patients (other than those with scheduled appointments) at 8.30am. This was due to the large number of telephone calls early in the morning. The reception was occasionally

closed to calls between 1pm and 2pm. The practice had a branch surgery in Normandy. The opening hours for the branch surgery were 8am to 5pm. The practice had run a GP and nurse surgery from 9am to 12pm on Saturdays. These surgeries were strictly by appointment only and the practice's telephone lines are not open during those hours.

There were a range of services for working age people (including those recently retired and students). The services include management of long-term conditions, and clinics covering a wide range of services for patients including asthma/COPD clinics, diabetes clinics, hypertension clinics, well woman/man checks, family planning services, weight management services, smoking cessation advice, blood pressure monitoring, blood tests, ECGs, vaccinations and immunisations, maternity care, and child development as well as travel health, safe travel tips, travel vaccinations, blood tests, and x-rays.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers, and those with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice had a range of services for people whose circumstances may make them vulnerable including management of long-term conditions, and clinics covering a wide range of services for patients including asthma/COPD clinics, diabetes clinics, hypertension clinics, well woman/man checks, family planning services, weight management services, smoking cessation advice, blood pressure monitoring, blood tests, ECGs, vaccinations and immunisations, maternity care, and child development as well as travel health, safe travel tips, travel vaccinations, blood tests, and x-rays.

Summary of findings

The practice had no specific lead for travellers. However, they had high users of their practice within the traveller community. The practice had success in offering immunisations. The practice was able to demonstrate a high level of knowledge of the traveller community. There are three local traveller sites.

The practice had links with bereavement counselling services.

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). 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. It carried out advanced planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice provided a range of services for people experiencing poor mental health (including people with dementia) that included management of long-term conditions, and clinics covering a wide range of services for patients including asthma/COPD clinics, diabetes clinics, hypertension clinics, well woman/man checks, family planning services, weight management services, smoking cessation advice, blood pressure monitoring, blood tests, ECGs, vaccinations and immunisations, maternity care, and child development as well as travel health, safe travel tips, travel vaccinations, blood tests, and x-rays.

The practice had a GP lead for mental health. The practice was aware of patients experiencing poor mental health. The practice offered appointments for counselling for people experiencing poor mental health. The practice ensured that patients experiencing poor mental health got physical health checks. The practice had care plans for patients experiencing poor mental health. The practice had experience of undertaking a number of Power of Attorney cases. They had also had experience of a patient who needed an Independent Mental Capacity Advocacy service. Advanced directives were rare in the practice's experience. The practice had undertaken best interest principle work.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed that 89% would recommend the practice, satisfied with phone access was 75.9%, people who were satisfied with the opening hours was 70%, the percentage of people who saw/spoke to a nurse or GP on the same or next day is 44.1%, for reporting good or overall experience of making appointments is 73.9% and the percentage who know how to contact an out-of-hours GP service is 46.5%. These practice results were higher than the local average for the percentages who would recommend the practice, or who saw or spoke to a nurse or GP on the same or next day. The practice results were lower than the local average for the percentages who would recommend the practice for satisfaction with phone access, satisfied with the opening hours, reporting good overall experience of making an appointment, who know how to contact an out-of-hours GP service. The overall Quality and Outcomes Framework score for the practice was 97.5% which is higher than the overall QOF score for the clinical commissioning group area.

Areas for improvement

Action the service SHOULD take to improve

Ensure that the lock on the refrigerator is fixed.

The Fairlands 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 second CQC inspector, a GP and practice manager specialist advisor.

Background to The Fairlands Practice

The Fairlands Practice has approximately 12,100 patients registered with the practice. A range of services include management of long-term conditions, and clinics covering a wide range of services for patients including asthma/COPD clinics, diabetes clinics, hypertension clinics, well woman/man checks, family planning services, weight management services, smoking cessation advice, blood pressure monitoring, blood tests, ECGs, vaccinations and immunisations, maternity care, and child development as well as travel health, safe travel tips, travel vaccinations, blood tests, x-rays are offered. The practice is located in a part of Surrey with the lowest levels of income deprivation in the area and much lower than the than the England average. In Guildford and Waverley CCG area the percentage of children living in low income families is below the south east average, the actual number (23,330) is a concern as these children are more likely to experience poorer outcomes, including developmental problems, mental illness, substance misuse and poor educational attainment. The practice has a higher number of patients aged zero to four years, aged 5 to 14 years, aged under 18 years, aged 65 plus years and aged 75 plus years than the CCG average. The practice population also has a higher deprivation score and level of income deprivation (children and older people). The number of patients with long-standing health conditions, patients with health problems in daily life, patients with a caring responsibility, working status patients (paid work, or full-time education), and life expectancy are higher than the CCG average. It has a lower than CCG average for people aged 85 plus years, and those who are unemployed.

The practice is currently staffed by one senior partner and six partners. There are six female and four male GPs. The practice has one salaried GP, one GP retainer and one GP registrar. There is one nurse practitioner, one lead nurse, and five nurses. There is one practice manager, and a deputy practice manager. There is one senior administrator, one nurse administrator/reception member of staff, one reception supervisor, and nine reception staff. The practice staff includes three Health Care Assistants. One of the GPs is in the final year of their training and has been working full time at the practice since the summer of 2014. One of the GPs is also the clinical supervisor for Foundation Training doctors attached to the practice. One of the GPs hosts medical students who undertake a placement in the practice as part of their education.

This was a planned comprehensive inspection and the practice had not been inspected previously.

Services are provided from two locations:

Fairlands Medical Centre, Fairlands Avenue, Worplesdon, Guildford, GU3 3NA

And

Glaziers Lane Surgery, Glaziers Lane, Normandy, Guildford, Surrey,GU3 2DD

However, we only inspected Fairlands Medical Centre

The practice has opted out of providing out of hours services to their patients. There are arrangements in place

Detailed findings

for out of hours services to be provided by an alternative provider (NHS 111) when the surgery is closed. These are displayed at the practice, in the practice information leaflet and on the website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service on 31 October 2014 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 practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This practice had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting The Fairlands Practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Guildford and Waverley Clinical Commissioning Group (CCG). We carried out an announced inspection visit on 31 October 2014. During our inspection we spoke with patients and a range of staff, including GPs, a practice nurse and reception and administration staff.

In addition we reviewed 32 comment cards that had been completed by patients in the two weeks prior to our inspection. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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 patient's needs?
- Is it well-led?

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

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

The practice is situated in an area of Guildford which has much lower than average deprivation levels. The practice served a population with more patients under the age of 50 compared to England averages for other practices.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

The practice has undertaken significant event analysis in relation to blood collection, lithium monitoring, missed Multiple Sclerosis diagnosis and a nurse error regarding spirometry.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

We reviewed incidents and saw records were completed to record what happened and the action taken at the time of the event. We saw evidence of action taken after the event had occurred. Where patients had been affected by something that had gone wrong, they were given an explanation and informed of the actions taken. There were changes made following the events we reviewed.

We spoke with a GP about significant events. They were able to confirm the process used to reflect on significant events and identify any learning. The GPs told us that significant events were discussed at practice meetings every Monday. There was evidence to demonstrate how the practice had learned from these and that the findings were shared with relevant staff. A significant event had occurred and as a result a very tight protocol had been produced. The pharmacist was involved in the subsequent monitoring.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard 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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The practice has a safeguarding lead. The safeguarding lead was trained to Level Three for safeguarding children. The safeguarding lead kept a log of all safeguarding referrals made. The practice has ensured that all patients with safeguarding issues have been coded appropriately. The practice has a child protection register.

The practice staff were able to discuss safeguarding issues with the safeguarding lead. There was an example given of a safeguarding alert relating to a child. The practice staff responded appropriately to the incident.

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. However there was a broken lock on one of the refrigerators. The practice was aware of this and was in contact with the manufacturer to resolve the issue. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had a GP who was the medicines management lead.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

Good

Are services safe?

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. (include example you found).There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients at risk of hospital admissions who had been recently discharged from.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed 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.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken. There were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. Alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were addressed. The information was shared with GPs and patients were called for a medication review.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). GPs carried out medication reviews for patients who were prescribed medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The team was making 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, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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

Good

Are services effective?

(for example, treatment is effective)

such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, 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.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

The practice was not an outlier for the number of antibacterial prescription items prescribed per specific therapeutic group age-sex related prescribing unit. The practice was not an outlier for the ratio of expected to reported prevalence of Coronary Heart Disease (CHD). The practice was not an outlier for the ratio of Cephalosporins and Quinolones items as a proportion of antibiotic items prescribed.

The practice was not an outlier for the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA 1c is 64 mmol/mol or less in the preceding twelve months. The practice was not an outlier for the percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification 1-4 within the preceding 12 months. The practice was not an outlier for the percentage of patients with diabetes on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHG or less. The percentage of patients with schizophrenia, bi-polar affective disorder and other psychoses who had a record of alcohol consumption in the preceding 12 months. The practice was not an outlier for the percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding five years. The practice was not an outlier for the percentage of patients with atrial fibrillation, measured within the last 12 months who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy. The practice was not an outlier for the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding nine months is 150/90mmHg or less. The practice is not an outlier for the percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months. The practice was not an outlier for the percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent. The practice was not an outlier for the percentage of patients diagnosed with dementia whose care has been reviewed in a face to face review in the preceding twelve months. The practice was not an outlier for the percentage of patients with diabetes, on the register, who have a record of an albumin:creatitnine ratio test in the preceding twelve months. The practice was not an outlier for the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less. The practice was not an outlier for the percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March. The provider was not an outlier for the establishment and maintenance of a register of patients aged 18 or over with learning disabilities. The practice was not an outlier for the establishment and maintenance of a register of all patients in need of palliative care/support irrespective of age.

The practice had undertaken clinical audits relating to LARC, osteoporosis, and were in the progress of undertaking a clinical audit on Lithium.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one working towards an additional diploma in sexual and reproductive medicine, and other GPs with expertise in children's health. All GPs were up to date with their yearly continuing professional development requirements and all either have been

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, and cervical cytology. There were extended roles and staff were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice had a long history of training. All of the staff were involved in the training of registrars. Two GPs took the lead in planning training of registrars. The practice held monthly training meetings with registrars and held annual residential courses.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

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. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made X% of referrals last year 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.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved

in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and the patients were offered an annual physical health check. Practice records showed that they had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients had stopped smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was monitored. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening were offered.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Thirteen of the 32 were less positive. The common themes were; the lack of availability of appointments, the lack of availability of home visits, access to medicines prescribed by the hospital, lack of politeness of staff on the telephone, reception staff asking intrusive questions, access to the practice to by telephone to make emergency and routine appointments, administrative errors over cancelled appointments, the waiting time to see a GP, waiting times for prescriptions from the pharmacy, consistency of care with the same GP for long-term conditions, and an inappropriate comment made by a GP to a patient.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed that 89% would recommend the practice, patients satisfied with phone access was 75.9%, patients who were satisfied with the opening hours was 70%, the percentage of people who saw/spoke to a nurse or GP on the same or next day is 44.1%, patients reporting good or overall experience of making appointments was 73.9% and the percentage who know how to contact an out-of-hours GP service is 46.5%. These practice results were higher than the local average for the percentages of patients who would recommend the practice, or who saw or spoke to a nurse or GP on the same or next day. The practice results were lower than the local average for the percentages who would recommend the practice for satisfaction with phone access, satisfaction with the opening hours, patients who reported good overall experience of making an appointment, and patients who knew how to contact an out-of-hours GP service. The overall Quality and Outcomes Framework score for the practice was 97.5% which is higher than the overall QOF score for the clinical commissioning group area.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the

Good

Are services caring?

choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views in the majority of cases.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed that 89% would recommend the practice, satisfied with phone access was 75.9%, people who were satisfied with the opening hours was 70%, the percentage of people who saw/spoke to a nurse or GP on the same or next day is 44.1%, for reporting good or overall experience of making appointments is 73.9% and the percentage who know how to contact an out-of-hours GP service is 46.5%. These practice results were higher than the local average for the percentages who would recommend the practice, or who saw or spoke to a nurse or GP on the same or next day. The practice results were lower than the local average for the percentages who would recommend the practice for satisfaction with phone access, satisfied with the opening hours, reporting good overall experience of making an appointment, who know how to contact an out-of-hours GP service. The overall Quality and Outcomes Framework score for the practice was 97.5% which is higher than the overall QOF score for the clinical commissioning group area.

A range of services include management of long-term conditions, and clinics covering a wide range of services for patients including asthma/COPD clinics, diabetes clinics, hypertension clinics, well woman/man checks, family planning services, weight management services, smoking cessation advice, blood pressure monitoring, blood tests, ECGs, vaccinations and immunisations, maternity care, and child development as well as travel health, safe travel tips, travel vaccinations, blood tests, x-rays are offered.

The practice had a system for texting reminders or making calls to remind people of appointments.

The practice was not an outlier for emergency admissions per 100 patients on the disease register. The practice was not an outlier for the ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD). The practice was not an outlier for the percentage of patients aged over six months to under 65 years in the defined influenza clinical risk groups that received the seasonal influenza vaccination. The practice was not an outlier for average daily quality of hypnotics prescribed per specific therapeutic group age-sex related prescribing unit (STARPU). The practice is not an outlier for the number of ibuprofen and naproxen items prescribed as a percentage of all no-steroidal anti-inflammatory drugs items prescribed. The practice was not an outlier for the percent of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record in the preceding 12 months. The practice was not an outlier for dementia diagnosis rate adjusted by the number of patients in residential homes. The practice was not an outlier for the proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions in their care. The practice was not an outlier for the proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. The practice was not an outlier in the proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse, the nurse was good or very good at involving them in decisions

Good

Are services responsive to people's needs?

(for example, to feedback?)

about their care. The practice was not an outlier for the proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. The practice was not an outlier for the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good. The practice was not an outlier for the proportion of respondents to the GP patient survey who stated that they always or almost always see or speak to the GP they prefer. The practice was not an outlier for the percentage of patients who gave a positive answer to 'generally, how easy is it you to get through to someone at your GP surgery at your GP surgery on the phone?' The practice is not an outlier for the percentage of patients who were 'very satisfied' or 'fairly satisfied' with their GP practice opening hours.

The practice is an outlier for a regular (at least three monthly) multidisciplinary case review meeting where all patients on the palliative care register are discussed. The practice is an outlier for the regular (at least three monthly) multidisciplinary case meetings where all patients on the palliative care register are discussed. The practice is an outlier for the proportion of respondents to the GP patient survey who stated that in the reception area other patients can't overhear.

Tackling inequity and promoting equality

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

The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patients with disabilities.

The practice actively supported patients who have been on long-term sick leave to return to work.

There were three local traveller sites. The practice had no specific lead for travellers. However, they had a high number of users for their practice within the traveller community. The practice had success in offering immunisations to this population group. The practice was able to demonstrate a high level of knowledge of the traveller community.

The practice had a GP lead for mental health. The practice was aware of patients experiencing poor mental health. The practice offered appointments for counselling for people experiencing poor mental health. The practice ensured that patients experiencing poor mental health got physical health checks. The practice had care plans for patients experiencing poor mental health. The practice offered counselling services for patients. The practice had experience of undertaking a number of Power of Attorney cases. They had also had experience of a patient who needed an Independent Mental Capacity Advocacy service. One of the GPs had a particular interest in psychiatry. Advanced directives were rare in the practice's experience. The practice has undertaken best interest principle work. However there was no regular contact with the mental health services.

Access to the service

The practice is open 8am to 6.30pm on weekdays. The reception desk opened for patients (other than those with scheduled appointments) at 8.30am. This was due to the large number of telephone calls early in the morning. The reception was occasionally closed to calls between 1pm and 2pm. The practice had a branch surgery in Normandy. The opening hours for the branch surgery were 8am to 5pm. The practice had run a GP and nurse surgery from 9am to 12pm on Saturdays. These surgeries were strictly by appointment only and the practice's telephone lines were not open during those hours.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and the majority were positive about the service experienced. Thirteen of the 32 were less positive. The common themes were; the lack of availability of appointments, the lack of availability of home visits, access to medicines prescribed by the hospital, lack of politeness of staff on the telephone, reception staff asking intrusive questions, access to the practice to by telephone to make emergency and routine appointments, administrative errors over cancelled appointments, the waiting time to see

Good

Are services responsive to people's needs?

(for example, to feedback?)

a GP, waiting times for prescriptions from the pharmacy, consistency of care with the same GP for long-term conditions, and an inappropriate comment made by a GP to a patient.

We reviewed the most recent data available for the practice on patient satisfaction. The practice results were lower than the local average for the percentages who would recommend the practice for satisfaction with phone access, satisfaction with the opening hours, patients who reported good overall experience of making an appointment, and patients who knew how to contact an out-of-hours GP service. However the overall Quality and Outcomes Framework score for the practice was 97.5% which is higher than the overall QOF score for the clinical commissioning group area.

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

Longer appointments were also available for patients who needed them and those with long-term conditions.

Listening and learning from concerns and complaints

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

We saw that information was available in the reception area and on the practice website to help patients understand the complaints system. The complaints system was brought to the attention of patients and they were therefore encouraged to make complaints. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. Complaints were discussed at team meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room.

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice away day and saw that staff had discussed and agreed that the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

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

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

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice has a transparent and open culture.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

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

Seeking and acting on feedback from patients, public and staff

The practice had a patient participation group. The practice had an active email group which provided a useful communication channel between the practice and their patients. The patients were encouraged to send their details to the practice manager. The practice encouraged patients who wanted to be contacted occasionally by email to open and complete the sign up form.

The practice has a patient representative. The patient representative has made a personal report of a meeting of the CCG public and patient forum.

The practice has a link on its website to the Fairlands and Normandy Surgeries patient survey results, minutes of the patient group meeting and action plan. The Fairlands

Are services well-led?

Good

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

Patient Group comprises 76 virtual members and the report details the characteristic of the group. This information includes; attendance, gender, ethnicity, and age. The survey was overseen by the practice manager and the patient representative. and was test driven and feedback provided by another patient. The survey was made available and promoted via the practice website and at both the practice locations by the practice's reception team in hard copy throughout February 2014. The receptionists were encouraged to actively promote the survey to the practice's younger patients (under 25). The practice found that it was difficult to engage this patient group. The practice has asked GPs to target under 25s and encourage them to speak to the practice manager and or join the virtual group to provide some feedback on the services offered and their relevance to teenagers and young adults.

The survey received 227 responses. The agreed next steps from the survey were to; recruit a nurse practitioner and adopt a new system for managing same day demand, review telephone demand at 8am and finalise how the new system might work, draft explanations about the new system and issue to the patient group for feedback before issue, issue patient communications through the media, implement the new system within 3-4 months, and the practice manager arranging another patient meeting to review progress on the new system. The review meeting was also going to consider a turn up and wait system as some members of the patient group members indicated that they felt this worked well at other locations.

The practice also had newsletters for patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at 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 staff away days where guest speakers and trainers attended.

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