Old Mill Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Old Mill Surgery on 11 August 2015. Overall the practice is rated as good.

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.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Information about how to complain was available and easy to understand.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). Changes had been made to the telephone system, with further changes planned so that patients had improved access to appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

Summary of findings

- 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 practice held an open evening at the practice at which stands were available providing information and guidance for patients on a range of topics such as Age UK, Guideposts, smoking cessation and a diabetic specialist team from the nearby George Eliot Hospital. Feedback from patients, agency representatives and staff was very positive and the practice planned to hold a further open evening over the winter period.
- A range of support services was offered for younger patients. This included contraception advice; a website page with information specifically for younger patients; chlamydia screening with packs available in the waiting room for patients to collect; younger patient vaccination clinics with particular focus on university meningitis vaccinations; online appointments, prescribing and patient summary; and text messaging.

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

Importantly the provider should:

- Ensure that their consent policy and procedure is followed specifically where the policy states that written consent should be obtained and recorded for invasive treatments.
- Ensure that best practice guidance is followed that advises a nurse should be in attendance when GPs fit contraceptive devices.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were robust safeguarding measures in place to help protect children and vulnerable adults from the risk of abuse. There were enough staff to keep patients safe.

Although chaperones were available for patients should they request this, GPs were not following best practice guidance that advised a nurse should be in attendance when GPs fitted contraceptive devices.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness. They produce and issue clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity to provide services and promoting good health for all patients. Formal consent was not always obtained from patients before treatment had been given, which was contrary to the practice's own consent policy.

Staff had received training appropriate to their roles and any further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to improve outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. We observed throughout the inspection that members of staff were courteous and very helpful to patients both at the reception desk and on the telephone, and that patients were treated with dignity

Summary of findings

and respect. Patients were very complimentary about the practice and commented that staff were very friendly, that they received excellent care from the GPs and nurses, and that the GPs took time to listen to them.

Patients said they were treated with compassion and they were involved in decisions about their care and treatment. Information about the services available to patients was easy to understand and accessible.

The practice recognised the needs of their patient population and linked with other agencies to provide services that ensured their care needs were being met.

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.

The practice had made improvements to the telephone system following feedback from patients about some difficulty in telephone access. On-going improvements were planned to make further improvements. Patients told us that urgent appointments were available the same day.

The practice building had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning.

The practice proactively sought feedback from staff and patients, which it acted on. There was an active patient participation group in place who responded to feedback from patients about ways that improvements could be made to the services offered. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients 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 patients, and offered home visits and rapid access appointments. Support service packs were available for patients with information and contact details they may need. This included access to a named nurse with a direct telephone number.

People with long term conditions

Good

The practice is rated as good for the care of patients 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. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The GPs and nurses made home visits to patients whose health or mobility prevented them from attending the practice for appointments. This included home visits for vaccinations such as flu and shingles as needed. Longer appointments were available for patients with specific needs such as patients with a learning disability.

Information packs were available for patients and their carers which included contact numbers for support groups should they be needed. The practice also provided a direct contact number for quick access to a named contact.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. 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 patients who had a high number of accident and emergency (A&E) attendances. Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Urgent access appointments were available for children and those with serious medical conditions. The practice offered child immunisation clinics twice weekly with later morning appointments

Summary of findings

for easy access and held specific children only flu clinics. The practice catered for children when visiting the practice with a play area in the reception area. Appointments were available outside of school hours and access to the premises was suitable for children and babies.

A range of support services was offered for younger patients. This included contraception advice; a website page with information specifically for younger patients; chlamydia screening with packs available in the waiting room for patients to collect; younger patient vaccination clinics with particular focus on university meningitis vaccinations; online appointments, prescribing and patient summary; and text messaging.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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.

Extended appointment times were available for those patients who had work commitments. These were available from 6am on Mondays to Thursday mornings and till 7.15pm on Friday evenings for pre-booked appointments. Saturday morning flu vaccination clinics were available and also some evenings to improve access for patients who had work commitments.

The practice was proactive in offering online services as well as a full range of health promotion and screening services that reflected the needs for this age group. This included a range of support services offered to younger patients such as contraception advice; a website page with information specifically for younger patients; chlamydia screening with packs available in the waiting room for patients to collect; younger patient vaccination clinics with particular focus on meningitis vaccinations for patients attending university; online appointments, prescribing and patient summary; and text messaging.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. For example, the practice had

carried out annual health checks for patients with a learning disability and all of these patients registered with the practice had received a review of their care. The practice also offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had advised vulnerable patients on how to access various support groups and voluntary organisations. Alerts were placed on these patients' records so that staff were aware they might need to be prioritised for appointments and offered additional attention such as longer appointments.

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 was registered as a safe place for vulnerable people to access when they felt at risk or in need of a place of safety.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advanced care planning and annual health checks for patients with dementia and poor mental health.

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) when they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published in 2015 showed the practice was generally performing at or slightly below local and national averages. Of 311 surveys sent out to patients 105 responses were received which represented a response rate of 34%. Results showed:

- 62% found it easy to get through to this practice by phone compared with a Clinical Commissioning Group (CCG) average of 66% and a national average of 73%.
- 92% found the receptionists at this practice helpful compared with a CCG average of 85% and a national average of 87%.
- 89% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.
- 92% said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 77% described their experience of making an appointment as good compared with a CCG average of 71% and a national average of 73%.
- 79% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 67% and a national average of 65%.
- 71% felt they don't normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards which were all positive about the standard of care received. Patients were very complimentary about the practice and commented that they found the staff very friendly, that they received excellent care from the GPs, nurses and reception staff. One patient commented that there had been occasions when telephone access had been difficult.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that their consent policy and procedure is followed specifically where the policy states that written consent should be obtained and recorded for invasive treatments.
- Ensure that best practice guidance is followed that advises a nurse should be in attendance when GPs fit contraceptive devices.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a CQC deputy chief inspector, a GP specialist advisor and an expert by experience (a person who has experience of using these services).

Background to Old Mill Surgery

The Old Mill Surgery is located within the town of Nuneaton in Warwickshire and provides primary medical services to patients. Nuneaton and the surrounding areas was historically an area of heavy industry and coal mining. As a result there are patients registered with the practice with a high occurrence of lung diseases.

The practice has a General Medical Services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice has four GP partners, a salaried GP and up to three trainee GPs at any one time. This includes two female GPs which provides a choice for patients. The GPs are supported by a practice manager, a medical secretary, four practice nurses two of whom job share, a health care assistant, as well as administrative and reception staff. There were 11045 patients registered with the practice at the time of the inspection.

The Old Mill Surgery is an approved training practice for doctors who wish to be become GPs. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer.

The practice is open from 8am to 6.30pm Monday to Friday each week with appointments available within these times. The practice is closed at weekends although flu vaccination clinics are held on Saturday mornings during the winter months. Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions, book and cancel appointments without having to phone the practice. The practice offers extended hours for pre-booked appointments from 6am some mornings and until 7.15pm on a Friday evening.

The practice does not provide an out-of-hours service but has alternative arrangements in place for patients when the practice is closed. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances. Information on the out-of-hours service is provided to patients and is available on the practice's website and in the patient leaflet.

The practice treats patients of all ages and provides a range of medical services. This includes specialist clinics for diabetes and chronic obstructive pulmonary disease (COPD) (lung disease). It also offers childhood immunisations, family planning, travel health vaccines, smoking cessation and a minor surgery service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before our inspection of The Old Mill Surgery we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Warwickshire North Clinical Commissioning Group (CCG), Healthwatch and NHS England Area Team to consider any information they held about the practice. We reviewed policies, procedures and other information the practice provided before the inspection. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 11 August 2015. During our inspection we spoke with a range of staff that included five GPs, the practice manager, two practice nurses, a medical secretary and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We reviewed 31 comment cards where patients and members of the public shared their views and experiences of the practice. We spoke with 10 patients who visited the practice during the inspection and spoke with the one patient on the telephone who was also a member of the patient participation group (PPG) at the practice.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patients' 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 patients
- Patients with long-term conditions
- Mothers, babies, children and young patients
- The working-age population and those recently retired
- Patients whose circumstances may make them vulnerable
- Patients experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients.

There was an open and transparent approach and a system in place for reporting and recording significant events. Patients who were affected by significant events received a timely and sincere apology and were told about actions the practice had taken to improve care. Staff had been trained to report significant events and understood the reason why this was necessary. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. There was also a 'near miss' board in the staff area on which information about any incidents was recorded.

We saw that electronic records of significant events were available to view as far back as 2012 with paper copies for many years prior to this. We saw that 24 significant events had been recorded during 2014 and included clinical, administrative and business incidents. Records demonstrated the willingness by staff to report and record incidents. Learning from these had been circulated by the practice manager to all staff and evidence was seen to confirm this.

We saw that all significant events were a standard agenda item and were discussed at six weekly clinical meetings. These meetings were attended by the practice manager, medical secretary, practice nurses, GPs, trainee GPs and the health care assistant. We tracked four such incidents that had been recorded within the last 12 months and saw that these had been completed in a comprehensive and timely manner. For example, we saw from minutes of a meeting held in August 2014 that there had been a referral delay due to changes in secondary care services. The practice had not been aware of these changes at the time so they implemented a system to ensure they monitored changes in other services that may impact on their patients care.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness. They produce and issue clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with gave us examples of recent alerts that were relevant to the care they were responsible for. They also told us that alerts were discussed at clinical meetings to make staff aware of those relevant to the practice and any action that was needed. The practice manager showed us an audit that was kept to track all the alerts received, with responses required, action taken and by whom recorded.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe, which included:

- Arrangements were in place to safeguard adults and children from the risk of abuse that reflected relevant legislation and local requirements. Staff told us that all policies were accessible to them. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was an identified lead member of staff for safeguarding concerns. The GP and the practice manager attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. 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 any child known to be at risk of harm or who was in the care of the local authority. This also included those children that were failing to attend for vaccination programmes.
- There was a chaperone policy available to all staff on the practice computer. We saw that a poster was prominently displayed in the reception area informing patients about the chaperone facility. A chaperone is a person who acts as a safeguard and witness for a

patient and health care professional during a medical examination or procedure. The practice manager told us that training was provided for non-clinical staff that may, in exceptional circumstances act as chaperones. This was confirmed by staff we spoke with and training records we looked at. Trained staff also demonstrated an awareness of the role of chaperones including for example, knowing where to stand when intimate examinations took place. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of patients barred from working in roles where they may have contact with children or adults who may be vulnerable. When chaperones had been offered a record had been made in patients' notes and this included when the service had been offered and declined.

- Although chaperones were available for patients should they prefer this, we found that GPs were not following best practice guidance that advised a nurse should be in attendance when GPs fitted contraceptive devices. This was discussed with the senior GP partner, the practice nurse and the practice manager who responded immediately and changed their procedures to ensure that a nurse was in attendance at all future appointments.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. All electrical equipment was checked to ensure that equipment was safe to use and clinical equipment was checked to ensure it was working properly. For example, electrical equipment safety testing had been carried out in August 2014 and calibration of equipment such as defibrillators (used to restart a persons' heart in an emergency) and ear syringes had been carried out in August 2015. There was evidence that regular fire system checks had been carried out by a company employed by the practice, with the latest check completed in June 2015. The practice also held an asset register which detailed all the equipment held at the practice. The register also recorded that checks had been carried out and equipment was safe to use. This register had been updated in March 2015.
- The practice also had a variety of other risk assessments in place to monitor safety of the premises which included the control of substances hazardous to health, infection prevention and control (IPC) and legionella (a germ found in the environment which can contaminate water systems in buildings). For example, we saw a completed risk assessment for adverse weather conditions. This included a gritting checklist for the ramp to the building to ensure this was kept ice free during the winter.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be visibly clean and tidy. Two of the practice nurses were the infection prevention and control (IPC) clinical leads who liaised with the local infection prevention and control teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- Regular infection control audits were undertaken and were available as far back as 2011. We saw evidence that action was taken to address any improvements identified as a result of audits carried out. For example, an external infection control audit had been carried out by the IPC lead in June 2015 and two issues had been identified and acted upon. This included a box used for the disposal of sharp blades and needles which had no start date recorded.
- Staff were encouraged to follow hand washing techniques and regular audits were carried out with staff to check this. An ultra violet lamp was used to scan staff hands to check that they were cleaned appropriately. Records showed that staff had achieved 100% in the hand washing audit carried out in 2015.
- There were suitable arrangements in place for managing medicines, including emergency medicines and vaccinations to ensure patients were kept safe. This included obtaining, prescribing, recording, handling, storing and security of medicines. Regular medicine audits were carried out with the support of the Clinical Commissioning Group (CCG) pharmacist to ensure prescribing was safe and in line with best practice guidelines. Prescription pads were securely stored and there were systems in place to monitor their use.
- We looked at four staff files, including those for a receptionist, a locum GP and a practice nurse to see

whether recruitment checks had been carried out in line with legal requirements. The files showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups to ensure that enough staff were available each day. Staff confirmed they would also cover for each other during holiday periods and at short notice when colleagues were unable to work due to sickness. There was a strong ethos of shared responsibility from the staff we spoke with who recognised the difficulties that may arise such as increased demands during winter weather. The practice had strategies in place to ensure the practice was staffed and patients were cared for. 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.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. We saw that all the emergency medicines held were logged and expiry dates were monitored and recorded. These included medicines for the treatment of cardiac arrest (where the heart stops beating), a severe allergic reaction and low blood sugar. All the medicines we checked were in date and fit for use. The practice had a defibrillator (used to restart a person's heart in an emergency) and oxygen with both adult and children's masks available. Staff were trained to use these.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. This included situations such as adverse weather conditions and migration to new computer system. The plan was available to all staff and included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness. They produce and issue clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. The practice had systems in place to ensure this information was shared with all clinical staff so they were kept up to date. Staff we spoke with gave us examples of changes to their practice based on national guidance.

The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. The practice nurse told us they accessed NICE guidance and actioned recommendations where these were applicable. Shared records were in place to enable best practice guidance to be stored and shared by all staff. We saw minutes of clinical practice meetings where new guidelines had been discussed and shared.

Clinicians told us and meeting minutes confirmed that patients with new cancer diagnosis were discussed at clinical meetings to ensure the appropriate care and referral pathways were followed. This ensured that there were no delays to their care and treatment.

GPs at the practice each led in specialist clinical areas such as diabetes, heart diseases, chronic obstructive pulmonary disease (COPD) (lung diseases), minor surgery and cancer. The practice nurses supported this work, which allowed the practice to focus on specific conditions. The GPs regularly attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support to keep their skills and expertise up to date.

Management, monitoring and improving outcomes for patients

The practice had a system in place for completing regular clinical audits. Clinical audits are carried out to demonstrate quality improvement and ensure that all relevant staff are involved to improve care, treatment and patients' outcomes. We saw clinical audits that GPs had completed over a number of years as part of the practice's quality monitoring process. Following each clinical audit changes to treatment or care were made where relevant to improve outcomes for patients. For example, an audit had been carried out in January 2014 following NICE guidance for prescribing of a particular medicine. The guidance recommended that treatment of patients with this medicine should only be continued for a period of 12 months. A database search was carried out to identify patients who were prescribed this medicine. The initial audit identified 35 patients and following case reviews 18 patients were found to be prescribed within recommendations. As a result of this audit changes were made to procedures and dates when patients commenced this treatment were highlighted on their records, together with the expected duration of the treatment.

We looked at audits where audit cycles had been completed. For example, we looked at minor surgery audits that had been completed for 2013 and 2014. The 2013 audit had seen an increase in the number of minor surgery procedures carried out over the previous year, and the post-surgery infection rate had consistently remained below 1-2% of the patients treated. This audit showed that no changes to procedures had been required. The audit for 2014 showed results similar to 2013 although there had been a slight decrease in the number of procedures carried out over the year. As previously no changes in procedures had been required. The audits were scheduled to be carried out each year to ensure that procedures were effective and that appropriate outcomes for patients were maintained.

The practice took part in regular audits as part of the CCG local incentive scheme to make improvements in areas such as prescribing of anticoagulant medicines. Anticoagulants are medicines that help prevent blood clots. They are given to patients considered at high risk to reduce their chances of developing serious conditions such as strokes and heart attacks. A data base search had been carried out and a programme of rolling audits had been set up with the initial audit carried out in June 2015. A re-audit was scheduled for January 2016 so that treatment was monitored and any changes required to patients' treatment would be made on a regular basis.

The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK intended to improve the quality

Good

Are services effective?

(for example, treatment is effective)

of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results for the practice were 93.6% of the total number of points available, with 7.8% exception reporting. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition.

Data from 2014/2015 showed:

- Performance for diabetes related indicators such as patients who had received an annual review including foot examinations was 83.02% which was slightly lower than the national average of 88.35%.
- The percentage of patients with hypertension (high blood pressure) having regular blood pressure tests was 77.19% which was slightly lower than the national average of 83.11%.
- Patients with mental health concerns such as schizophrenia, bipolar affective disorder and other psychoses with agreed care plans in place were 97.5% which was higher than the national average of 86.04%.
- The proportion of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 92.5% which was above the national average of 83.82%.

The practice had carried out audits to examine reasons where data showed below average indicators. For example, a dementia audit was completed to identify patients with a possible diagnosis of dementia where there may have been errors in coding. This may have contributed to the low rates of dementia diagnosis on practice registers. The results of the audit showed that although 106 patients had been coded with a dementia diagnosis five of these had not been included in the QOF report. The practice planned to continue the audits and ensure that all GPs used the dementia assessment tools to help them with diagnosing dementia in patients.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. For clinical staff the induction programme covered clinical supervision as well as introduction to systems and processes used by the practice. Staff said the induction programme was very thorough and detailed. They confirmed this had included role specific shadowing with pre-arranged supervision sessions throughout the induction programme.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, meetings, appraisals, and clinical supervision. All staff had received an appraisal within the last 12 months.
- The GP took part in required annual external appraisals and told us they had recently been revalidated. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.
- The practice was a training practice for trainee GPs. The GP told us they would take up to three trainee GPs at a given time although recent experiences had shown a low and reducing number of trainees wanting to work in general practice.
- We saw evidence that the training completed by staff included safeguarding, chaperoning, confidentiality, basic life support and fire safety. Staff had also completed training about customer care, managing patients' expectations and domestic abuse. Training was available through e-learning and in house or external training sessions. The practice manager told us that all staff training was planned with staff in December each year. Training was then scheduled throughout the coming year to take place during staff protected learning times. The practice manager also had a system in place for monitoring when training was due for each member of the practice team.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk

Good

Are services effective?

(for example, treatment is effective)

assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared in a timely way, for example when patients were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a quarterly basis and that care plans were routinely reviewed and updated. For example, from minutes of meetings that had taken place throughout 2015 we could see that health visitors, the practice nurse, district nurses and the palliative care team had attended these meetings. We saw that discussions had included concerns about safeguarding adults and children, as well as those patients who needed end of life care and support.

A palliative care register was maintained and the practice discussed the care and support needs of patients and their families at the multidisciplinary meetings. All patients had up to date care plans and these were also shared with other providers such as the out-of-hours service.

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

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance, although this was not always consistent. The practice had a consent policy and procedure in place but we found this had not always been followed. For example, GPs confirmed they obtained verbal consent from patients when carrying out minor surgery but this had not always been formally recorded. Following our inspection the practice manager confirmed that changes had been made. Consent was obtained before intervention or treatment was given and was now being recorded. The practice manager confirmed that patient consent forms were available for completion and were now scanned into patient records.

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young patients, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was not however, monitored through records checks carried out by the GP to ensure it met the practices responsibilities within legislation and followed relevant national guidance. The practice manager confirmed that a process had been put in place following the inspection to ensure regular checks were carried out.

The GPs also demonstrated a clear understanding of Gillick competence. The 'Gillick Test' helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering help. For example, the practice kept registers of patients identified as being at high risk of admission to hospital. Registers of patients from vulnerable groups such as patients with a learning disability were also held. QOF data for 2014 to 2015 showed that annual reviews had been carried out in the last year for all these patients. The GPs we spoke with told us that more time was given for review appointments to make sure there was enough time to be able to give patients full explanations of their condition and treatment as needed.

It was practice policy to offer a health check with the practice nurses to all new patients registering with the practice, to patients who were 40 to 70 years of age and also some patients with long term conditions. The NHS health check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations. The GPs and practice nurses told us they would also use their contact with patients to help maintain

Good

Are services effective?

(for example, treatment is effective)

or improve mental, physical health and wellbeing. For example, by promoting the benefits of childhood immunisations with parents or by carrying out opportunistic medicine reviews.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 74.49%, which was below the national average of 81.88%. The practice told us they had systems in place to encourage patient participation in screening and focussed on these to drive improvements in patient uptake. For example, there was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Patients who had not completed screening were highlighted on the computer records. These prompted staff to remind and encourage patients to take part in the screening programme, to discuss with the patient the need for screening and hand the patient a slip to go to the appointment desk to make an appointment. Cytology appointments were offered at any time during the day Monday to Friday to allow flexible access for patients. The practice told us that they acknowledged improvements were needed in the number of patients taking part in the screening programmes. In response to this they were making focussed efforts to follow their recall procedures and the use of opportunistic reminders to achieve an increase in uptake for all screening programmes.

Childhood immunisation rates for the vaccinations given were variable with some rates slightly below, on par or slightly above average rates when compared with national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94.7% to 100% and five year olds from 91.7% to 99.2% which compared with CCG rates of 98.2% to 100% and 95% to 99% respectively.

Flu vaccination rates for the over 65s were 68.89% which was lower than the national average of 73.24%. The rates for those groups considered to be at risk were 51.7% which was slightly lower than the national average of 52.29%. The practice told us that they actively encouraged vaccinations and worked with other agencies such as the midwifery team and health visitors to improve this.

The practice held clinics on a Tuesday and Thursday. These were walk-in sessions with two nurses vaccinating children from 9.30am to 12pm to ensure mothers could attend if they had other schoolchildren. Where a child fails to attend clinics the practice writes to the parents explaining the need for vaccination and offer appointments with a nurse at any time during the week.

The practice told us their vaccination figures had been static for over 10 years and identified that the current rates were a reflection of a number of families that were chronic non-attenders who despite various attempts refused to attend vaccination appointments with their children. The practice also had a significant number of new children that had moved into the area from countries such as Poland and India. Some parents were unable to provide immunisation history and the practice told us that adding these reasons to the new computer programme had been difficult. Work to add the information was continuing and the practice was confident this would show improvements in data for the next report. The practice action plan showed plans to consistently promote the vaccination programme and target those children that were failing to attend.

A comprehensive range of leaflets were available in the reception and waiting area of the practice. Practice information was translated into a variety of languages, and specific information about travel vaccines was available for travellers.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone, and that patients were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and offered them a private room to discuss their needs.

We received 31 comment cards which were very positive about the standard of care received by patients at the practice. Patients were very complimentary about the practice and commented that staff were very friendly, that they received excellent care from the GPs and the nurses at the practice. They commented that GPs always took the time to listen to them. These comments were confirmed by the 10 patients we spoke with during our inspection and from the patient we spoke with on the telephone.

Results from the national GP patient survey published in July 2015 showed that the practice scored varied results with slightly below average, average or above average results. These were in relation to patients' experience of the practice and the satisfaction scores on consultations with GPs and nurses. For example:

- 88.1% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 88.7% and national average of 88.6%.
- 84.3% said the GP gave them enough time which was slightly lower than the CCG average of 87.2% and national average of 86.8%.
- 94.5% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.9% and national average of 95.3%.
- 87.5% said the last GP they spoke to was good at treating them with care and concern which was above the CCG average of 85.8% and national average of 85.1%.
- 91.3% said the last nurse they spoke to was good at treating them with care and concern which was above the CCG average of 90.5% and national average of 90.4%.
- 91.8% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84.7% and national average of 86.9%.

This survey represented a return rate of 33.8% of the patient population for the practice.

Care planning and involvement in decisions about care and treatment

Patients told us through the comment cards that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patients commented that they only had praise for the service they received, that the GPs took time to listen and the nurses were helpful and reassuring with their treatment and care.

Patients we spoke with during the inspection told us they were happy with the way their appointments were managed, that the GPs took the time to listen to them and always took the time to explain their care to them when they did not understand.

Results from the national GP patient survey published July 2015 showed that most patients surveyed had responded below average to questions about GPs and nurses explaining things to them, and above average to questions about their involvement in planning and making decisions about their care and treatment when compared with the CCG and national averages. For example:

- 85% said the last GP they saw was good at explaining tests and treatments which was slightly below the CCG average of 88% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.

The practice told us they were surprised by the results of the national survey given the results of their own patient survey for December 2014 and January 2015, and the PPG survey completed in November and December 2014. A PPG is a group of patients registered with a practice who work

Good

Are services caring?

with the practice to improve services and the quality of care. The purpose of the PPG was to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients. These had both indicated higher responses and had not reflected the results of the national survey.

The results of the national survey were shared with all staff and at PPG meetings and ways to make improvements were discussed. An action plan was put in place. The practice planned to carry out another survey which the PPG had agreed to do during November 2015. The survey would be analysed externally, reported on and discussed with PPG and practice staff, published on the practice's website with action plans put in place where required.

Patient and carer support to cope emotionally with care and treatment

There were notices and leaflets available in the patient waiting room which gave information to patients on how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all patients who were carers and the practice supported these patients by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them. This was available in the reception area of the practice.

In some of the CQC comment cards patients had described how their GP and other members of the practice team had supported them and cared for them or a family member through extremely difficult, distressful and life changing circumstances. These had included critical illness and bereavement.

Staff told us that if families had experienced bereavement the GP telephoned them and often visited to offer support and information about sources of help and advice. Leaflets giving bereavement support group contact details were also available to patients in the waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice took part in regular meetings with NHS England and worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. The practice manager confirmed that they and the GP regularly attended the CCG meetings.

Services were planned and delivered to take into account the needs of different patient groups and to ensure flexibility, choice and continuity of care. For example:

- A range of services were provided for elderly patients that included osteoporosis clinics, over 75 years' health checks and individual care plans, and dementia clinics. Support service packs were available for patients giving them information and contact details they may need. This included access to a named nurse with a direct telephone number. The GPs and nurses made home visits to patients whose health or mobility prevented them from attending the practice for appointments
- Patients with long term conditions had access to a range of clinics associated with their conditions such as arthritis, diabetes, lung diseases, cancer and mental health. Home visits were made to patients who were unable to attend the practice for regular reviews of their care and treatment. This included home vaccinations such as flu and shingles as needed. Longer appointments were available for patients with specific needs such as patients with a learning disability.
- Information packs were available for patients and their carers which included contact numbers for support groups should they be needed. The practice also provided a direct contact number for quick access to a named contact.
- Urgent access appointments were available for children and those with serious medical conditions. The practice offered child immunisation clinics twice weekly with later morning appointments for easy access. They also held specific children only flu clinics. The practice catered for children when visiting the practice with a play area in the reception waiting area.
- A range of support services was offered for younger patients. This included contraception advice; a website page with information specifically for younger patients; chlamydia screening with packs available in the waiting room for patients to collect; younger patient vaccination clinics with particular focus on university meningitis vaccinations; online appointments, prescribing and patient summary; and text messaging.
- Extended appointment times were available for those patients who had work commitments. These were available from 6am on Mondays to Thursday mornings and till 7.15pm on Friday evenings for pre-booked appointments. Saturday morning flu vaccination clinics were available and also some evenings to improve access for patients who had work commitments.
- A minor surgery service was provided by the practice which included joint injections and surgery for the removal of cysts.
- The practice promoted health awareness and health education such as NHS health checks, sexual health and screening, smoking cessation clinics and dementia screening.
- The practice had a mental health register and worked with a community psychiatric nurse and psychiatrist to develop joint management plans to meet patients' needs. The practice was registered as a safe place for vulnerable people to access when they felt at risk or in need of a place of safety.
- The practice used a range of methods to communicate with patients such as text messages and TV (providing information and health advice in the practice's waiting room). Interpreter services were available for those patients who did not have English as their first language. Staff also accessed translation services via the internet as necessary. Some of the GPs at the practice were multi-lingual and one member of staff was British Sign Language trained.
- There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice building was on one level. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. There were also two designated disabled parking bays near to the building entrance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. There was an answerphone message which gave the telephone number patients should ring depending on their circumstances. Information about the out-of-hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website. There was provision for patients with a hearing impairment at the practice. We saw signs within the waiting area to indicate a hearing loop was available and staff were aware of how to use this. There was a screen in the waiting area which provided visual prompts for patients to be aware that they were being called. A member of staff was trained in sign language which was helpful to help patients who used this means of communication.

The practice was open from 8am to 6.30pm Monday to Friday with appointments available from 8am to 6.30pm. The practice offered extended opening hours from 6am on some mornings and until 7.15 on a Friday evening for pre-booked appointments. Patients commented in the comment cards that these hours had improved access for patients who were working. The practice was closed at weekends.

Results from the national GP patient survey published July 2015 showed that patient's satisfaction with how they could access care and treatment was generally above local and national averages. For example:

- 82% of patients were satisfied with the practice's opening hours, which was above the CCG average of 75% and national average of 75%.
- 62% of patients said they could get through easily to the surgery by phone which was below the CCG average of 66% and national average of 73%.
- 77% of patients described their experience of making an appointment as good which was above the CCG average of 71% and national average of 73%.
- 79% of patients said they usually waited 15 minutes or less after their appointment time which was above the CCG average of 67% and national average of 65%.

We received 31 comment cards which gave a positive response about access to services at the practice. Patients commented that they were always able to get an appointment when they needed one although one patient commented that it was difficult to get through on the telephone sometimes. Two patients commented that early appointments had been a great improvement.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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. Staff we spoke with were able to describe to us the procedure to follow should a complaint be received.

We found that there was an open and transparent approach towards complaints. Accessible information was provided to help patients understand the complaints system on the practice's website and in a complaints leaflet made available at the practice. We saw that information about complaints was available in the practice leaflet and advised contact details for patients should they wish to make a formal complaint. This included contact details for the PPG chair for patients to share issues or make suggestions for improvements. Patients commented through the comments cards that they were aware of the process to follow should they wish to make a complaint, but they had not needed to do so.

We saw from records that the practice had recorded all complaints which included details of action taken, responses to patients and any changes to practice in response to these complaints. The practice manager completed a complaints report each year to review the complaints received, the processes followed, outcomes of the complaints and any themes or trends identified for learning opportunities. We looked at the annual report from the 2014 to 2015 year and saw that 10 complaints had been received from patients. Of these 10 complaints five had been associated with a particular staff group. Complaints regarding attitude of staff had been discussed with the individuals concerned and with the staff team. Role specific training had been scheduled within the

Good

Are services responsive to people's needs?

(for example, to feedback?)

training plan for this year. Evidence was available to demonstrate that learning was considered with every complaint received and that this learning was shared with staff both individually and at team meetings.

The practice manager told us they took all complaints seriously and considered them to be upheld if a patient felt there had been a failure by the practice when they had raised concerns.

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 sent us a copy of their statement of purpose prior to the inspection. This told us that their aim was to provide high quality care to their patients through their commitment to training, education and learning to meet the needs of patients and the advances in primary care.

The practice told us about their plans for the future which included the retirement of a GP partner and the succession plan that was in place in preparation for this. There was evidence that this process had been started with the recent recruitment of a salaried GP. Staff told us they were supported to train and develop beyond their roles and move into positions with greater responsibilities. There was positive and constructive engagement with staff and a high level of staff satisfaction.

There were positive examples of how the practice's vision and ethos were implemented by the staff team working together to maintain high standards, deliver positive health outcomes for patients and foster a supportive work environment. We saw examples of how the staff team worked together and supported each other throughout the inspection.

The practice told us their building had been extended and modified on three separate occasions over the past few years. They told us they were proud of their building and what had been achieved to improve the range of services offered by the practice and other agencies. There were future plans in place for a Marie Stopes pregnancy termination clinic to be held at the practice.

Governance arrangements

The practice had a framework in place that supported the management and delivery of services at the practice to ensure that patients received good quality care. This included:

- A clear staffing structure and that staff were aware of their own roles and responsibilities. A staff list was available that documented designated staff and their respective roles with their specialities recorded.
- Practice specific policies were available to all staff. We looked at a number of policies and saw that these had been kept under regular review. For example, all policies and procedures were reviewed in April each year. Staff knew where to locate policies and procedures and confirmed these were located on the practices computer system as well as paper copies held in the practice mangers office.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements to the services provided by the practice. For example, following feedback from the annual surveys about difficulties with telephone access the practice carried out an audit on the telephone system. This included how long patients were on the telephone and whether appointments had been given within 24 hours. As a result of this audit the telephone system had been reviewed and additional lines had been added to improve access.
- Involvement in internal and external audit, including clinical audits to monitor quality and identify areas for improvement. For example, there was a monitoring lead for the practice to review and monitor Quality Outcomes Framework (QOF) data. The lead told us they also produced graphs and held discussions during team and clinical meetings to ensure all staff were kept updated and highlight where improvements were needed. Minutes of meetings confirmed these discussions took place.
- Structured processes were in place to monitor safety including the maintenance of equipment. We saw evidence of routine risk assessments carried out to ensure that procedures were appropriate for each potential risk identified. Managing risks were discussed at relevant practice and team meetings and changes made to procedures where required. For example, a patient had been incorrectly booked in for an appointment. This had been reviewed and evidence was seen that procedures had been revised following discussion with the staff team.
- The practice held meetings to share information, to look at what was working well and where improvements could be made. We saw minutes of these meetings and noted that complaints and significant events were discussed. Staff we spoke with confirmed this.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice had a system in place for the management of alerts from the

Are services well-led?

Good

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

Medicines and Healthcare products Regulatory Agency (MHRA). The practice manager received alerts and ensured action was taken on those alerts relevant to the practice.

Leadership, openness and transparency

The GPs at the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The GP was visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The GP encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Staff confirmed that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. They told us they were confident they would be supported if they needed to raise any issues or concerns. Staff said they felt respected, valued and supported, by everyone in the practice. They told us that everyone worked together well as a team. We saw minutes of meetings to confirm that staff had raised issues for discussion that they had described to us.

Seeking and acting on feedback from patients, the public and staff

The Old Mill Surgery worked with their patient participation group (PPG) to improve their services by learning from and listening to their patients. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG was to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients.

There was evidence that the practice and the PPG worked proactively together to obtain patient views and experiences and respond to these. For example, a raised chair had been requested and provided that was more suitable for patients who may have had a hip operation and found the usual chairs too low for them to sit in. During the summer months when the weather had been hot, cold drinks had been made available to patients in the waiting room. The practice manager told us they intended to provide a water cooler for future use and look to provide warm drinks in the colder weather.

We looked at PPG reports and action plans for 2012/2013, 2013/2014 and March 2015. Copies of reports were available to patients on the practice's website and on the PPG information noticeboard. The reports detailed a review of feedback taken from a variety of sources such as the smiley face patients survey, staff appraisals and an annual patient survey carried out by the PPG. The smiley face survey was devised by the practice in 2010 in which patients gave feedback according to the facial expression option they felt was applicable to their experience. The smiley face surveys were reviewed quarterly and gave the practice on-going checks on the services provided.

The PPG analysed the results on a quarterly basis and improvements and suggestions had been introduced for discussion at the meetings. Improvements had included additional toys in the waiting area, a barrier system at reception to ensure patient confidentiality, an audit of missed appointments and an audit of telephone answering times.

We spoke with the PPG chair over the telephone following our inspection. Through discussion they confirmed the findings of the report and also the difficulties around telephone access that had been experienced by many patients. They told us that practice staff however worked unbelievable hours to cater for working patients with early morning appointments and late evenings. They confirmed that the survey results had shown that 98% of the patients had been complimentary about the practice, commenting that all staff were very friendly and approachable when patients were trying to arrange appointments.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. Staff told us it was good to work at the practice, they had the training they needed, the support they needed and really enjoyed being there working as part of the team.

Innovation

The practice held an open evening at the practice at the beginning of August 2015 in which they welcomed patients and members of the community. Various stands were available providing information and guidance for patients on a range of topics such as Age UK, Guideposts, smoking cessation and a diabetic specialist team from the nearby George Eliot Hospital. One of the GPs stayed after appointments had ended so that patients who wished to

Are services well-led?

Good

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

speak with a GP could do so. Members of the PPG also attended the open evening to provide information about their role and function within the practice. Feedback from patients, agency representatives and staff was very positive and the practice planned to hold a further open evening over the winter period.