North Brink Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at North Brink practice on 23 June 2015. The overall rating for this practice is good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

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

- The practice was a friendly, caring and responsive practice that addressed patients' needs and that worked in partnership with other health and social care services to deliver individualised care.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Risks to patients were assessed and well managed.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff were supervised and supported and any further training needs had been identified and planned for.
- There was a clear leadership structure and staff felt supported by management.

We saw two areas of outstanding practice:

- The practice provided a same day clinic operated by four nurses supervised by a GP. This had increased the number of patients that could be seen at an on the day appointment to 500 a week. The practice had set a target to increase this to 750 per week.
- The practice had a well embedded learning culture for staff through the provision of internal and external training as well as an annual training budget the equivalent of two weeks wages per year. The practice

Summary of findings

linked specialised training in, for example, chronic diseases for nursing staff to an increase in basic salary. Staff reported that they felt well supported to develop and improve their skillset.

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

Importantly the provider should :

- Ensure all staff complete training deemed mandatory by the practice, for example basic life support.

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. When incidents occurred these were investigated to help minimise reoccurrences. 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. Patients including children, who were identified as being at risk, were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe.

Premises were clean and risks of infection were assessed and managed. There were health and safety and infection prevention and control policies in place. The practice had suitable equipment to diagnose and treat patients and medicines were stored and handled safely.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' mental capacity and promoting good health. Staff had received training appropriate to their roles and were there were gaps 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 except for some members of the nursing team. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with others in the area 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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said 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. Information about how to complain was available on request and easy to understand and evidence showed that the practice responded well to issues raised. Learning from complaints was shared with staff and other stakeholders.

The practice had adapted its appointments system to meet the needs of patients by offering early morning appointments and also appointments later in the day. They offered online booking for appointments for ease.

Are services well-led?

Good

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. Staff had received inductions and attended staff meetings.

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.

A community nurse practitioner was employed with specific experience in palliative care and chronic diseases.

A home delivery service was available for medication from the dispensary and an associated on-site pharmacy.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. 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 staff worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice provided on-site anti-coagulation services. Nurses provided home visits to patients with chronic diseases and a community nurse practitioner was employed to provide their skills in the community. The practice also offered a virtual clinic for patients with chronic diseases.

Residential and nursing homes were visited routinely by the nurse practitioner and/or GP.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people on the safeguarding register. Immunisation rates were in line with local averages 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. Women's Health clinics were available.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. 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.

Clinic times were flexible and included mornings, lunchtime and evenings. Telephone appointments were available.

People whose circumstances may make them vulnerable

Good

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

The practice employed three nurse practitioners, of which one was specifically employed as a community nurse practitioner. This allowed the skills that this type of nurse provides to be delivered in patients' homes and local care homes for acute and pre-planned visits. The nurse practitioners provided weekly ward rounds in local nursing homes and managed all acute patients. They also undertook medication reviews and dementia reviews for these patients. Outcomes were coordinated with multidisciplinary reviews to deliver the most appropriate care.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 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 advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations, including self-referred counselling for 17-25 year olds. 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.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We collected 15 comment cards; comments indicated that patients were very satisfied with the support, care and treatment they received from the practice and how useful the same day, GP-led, nurse clinic was for accessing urgent appointments. Two cards contained comments around difficulties in obtaining a suitable appointment and one comment criticised the telephone procedure when phoning the practice for an appointment.

We spoke with seven patients during our inspection, including two members from the virtual patient reference group (PRG). The PRG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PRGs are a group of patients registered with a practice who work with the practice to improve services and the quality of care. The patients we spoke with told us that they felt the practice was clean. They also expressed their opinion that the practice provided a very good personal service and that GPs and nurses delivered good clinical care, which acknowledged patients' concerns. Patients we spoke with confirmed that they could always get an urgent appointment with a doctor but were aware of difficulties with booking routine appointments. One patient we spoke with commended the referral processes to other care providers and another patient commented negatively around the consistency in dispensing medication.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff complete training deemed mandatory by the practice, for example basic life support.

Outstanding practice

- The practice provided a same day clinic operated by four nurses supervised by a GP. This had increased the number of patients that could be seen at an on the day appointment to 500 a week. The practice had set a target to increase this to 750 per week.
- The practice had a well embedded learning culture for staff through the provision of internal and external training as well as an annual training budget the equivalent of two weeks wages per year. The practice linked specialised training in, for example, chronic diseases for nursing staff to an increase in basic salary. Staff reported that they felt well supported to develop and improve their skillset.

North Brink Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector and included a GP specialist advisor, a practice manager specialist advisor, a nurse specialist advisor and a CQC medicine optimisation inspector.

Background to North Brink Practice

North Brink practice in Wisbech, Cambridgeshire provides services mainly to patients living in Wisbech and the surrounding area. The practice is a partnership of seven GPs. The practice also employs one salaried GP. There are also 11 nurses and three nurse practitioners, supported by three healthcare assistants.

The clinical team is supported by a practice manager, an assistant practice manager, a clinical performance manager and a site maintenance manager. There is a team of 17 patient services workers lead by a patient services manager, a team of two finance workers led by a finance manager and team of nine dispensers lead by a dispensary manager.

The practice is a training practice.

The practice has a patient population of approximately 19500. The practice is open Monday to Thursday between 08:00 and 20:00 and on Friday between 08:00 and 18:30.

Extended hours are provided on Monday to Thursday evenings until 20:00. The practice website details how patients may obtain services out-of-hours.

The practice had received the Quality Practice Aware from Royal College of General Practitioners in 2005 and was re-accredited with this in 2011.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. During our inspection on 23 June 2015 we spoke with a range of staff including GPs, practice nurses, dispensary, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. Reported incidents and National Patient Safety Alerts were used as well as comments and complaints received from patients to collate risk information. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Safety alerts were electronically distributed to the different department leads in the practice. We saw evidence of a log of these alerts and actions taken in one department but found it wasn't present in all departments. The practice told us they were developing a new process to evidence actions that were taken in line with safety alerts for each department in the practice but at the time of our inspection this was not yet established.

We reviewed 12 months of safety records and incident reports. These showed that the practice had managed risk and patient safety consistently over time and could show evidence of a safe track record. Learning and changes from incidents was shared with staff electronically.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. We saw emails to staff and were told of discussions with the staff where information was shared to improve patient safety. Staff told us that managers communicated with them regularly.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events and complaints and the actions resulting from them was documented in individual event records as well as a summary. The summary indicated trends such as patient misidentification or external organisation involvement. 30 events were captured on the summary. We reviewed four of these incidents and found they had been investigated and responded to appropriately.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology. The practice investigated complaints and kept a register of all complaints. This included actions taken as a result and learning from the complaints. The practice received 66 complaints last year, of which the practice had upheld 29 which were dealt with appropriately. We saw a summary which included reporting on the nature of the complaint and the findings. The summary defined trends such as complaints around the premises, treatment and clinical complaints and complaints related to staff attitudes. The practice was able to describe changes to services which were made a result of complaints and feedback. For example, a member of staff had received extra training around prescribing processes.

National patient safety alerts were disseminated electronically 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. For example the dispensary staff provided examples around prescribing alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing, administrative and reception staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. Two examples of recent incidents were described to us. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. This information was available on the practice's intranet.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern. The practice held monthly multi-disciplinary meetings during which safeguarding patients were discussed.

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 and vulnerable adults. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

We saw evidence that the practice worked collaboratively with local nursing homes and was proactive in providing tailored end of life care for patients in these homes with regular visiting regimes. The practice had proactively contributed to admission avoidance for long term condition patients in this home, through the involvement of nurse practitioners who helped care home staff complete appropriate assessments by visiting weekly and doing advanced care planning.

There was a chaperone policy, which was visible on the waiting room information screen. (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). Disclosure and Baring Service checks had been undertaken for staff that acted as chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example around prescribing costs and a more effective ordering procedure.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. The practice held stocks of controlled drugs and had standard procedures in place 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.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber in times of need, for example during busy times. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff told us, and records showed

that they had completed training appropriate to their role and kept up to date through external courses and in-house events. Staff had an annual appraisal and competency assessment.

We saw a positive culture in the dispensary for reporting and learning from medicines incidents and errors. Incidents and near misses were logged and reviewed. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice offered a choice of methods for people to order repeat prescriptions. A prescription ordering and delivery service was offered to housebound patients in rural areas, and people could be notified by text when their prescription was ready for collection.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept by the external cleaning company.

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. The lead would liaise with the local area Infection Control Lead if so required. They demonstrated a good understanding of their role.

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. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice' s infection control policy.

There was also a policy for needle stick injury and waste management. The needle stick injury policy was laminated and displayed on the wall so was visible to all staff. Staff understood the importance of ensuring that the policies were followed.

Records we viewed showed that infection control audits had been carried out to test the effectiveness of the general cleaning and infection control procedures within the practice. These audits demonstrated that the practice had systems in place for identifying and managing risks of infections. We saw evidence that an audit was done in 2014.

There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum.

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. We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor surgery or other interventions they performed.

The practice had a protocol for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks internally 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. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this.

The practice employed a full time maintenance manager who could deal with any maintenance or repair issue as they arose. All portable electrical equipment was routinely tested and displayed stickers indicating the next testing date was not due until August 2015. We saw evidence of up-to-date calibration of relevant equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were shown evidence of current DBS checks for all relevant staff.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and

non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota in place for clinical and non-clinical staff with an identified lead for each who held responsibility for planning adequate cover. Competency based spread sheets were available to ensure each 24 hour period was covered with an appropriate skill base and specialist trained staff. Staff we spoke with confirmed these arrangements worked well. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

The practice was in the process of completing the recruitment of six nurses and three non-clinical staff. We saw evidence that good induction processes were in place, with tailored induction events for new staff available.

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 CCTV, accident reporting, checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice employed their own maintenance manager who undertook all maintenance and health and safety checks.

We saw that logs of incidents, complaints and significant events had been kept at the practice and they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service.

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including an Automated External Defibrillator (AED, a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm) and oxygen were available for use in the event of a medical emergency. The equipment was checked regularly to ensure it was in working condition. Records indicated that nine members of staff (clinical and non-clinical) were overdue refresher training for basic life support. We were informed that this training was being addressed and it was overdue due to the resignation of the trainer from the practice, it was planned that this was to be addressed in-house.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest and anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use, we saw evidence of this. We checked all the medicines and found one set of medicines used to help breathing was out of date. This was amended immediately in our presence.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Each risk was detailed and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of utilities and emergency key protocols. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. A copy was held by several of the managers and off site.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw that the fire safety and evacuation procedure was displayed throughout the practice. Fire alarm tests were conducted weekly. Staff we spoke with were aware of the procedures to follow in

Good

Are services safe?

the event of a fire or other untoward event which would require the building to be evacuated. All managers were trained as fire marshal and the practice told us they intended to train all staff to fire marshal level in the future.

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. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient has fair access to quality treatment. We saw evidence that recent diabetes related guidelines were incorporated in patient care.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. 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 saw the practice completed reviews of case notes for patients, for example those with diabetes, to show they were on appropriate treatment and had received regular reviews of their health and medicine.

The practice had devised and adopted their own triage system for appointments. This system created a clear pathway to ensure that the patient was seen by the appropriate member of staff. It included information about differing patient needs and which member of staff could best address this.

The practice used computerised tools to identify patients with complex needs who had a named GP and multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, involving a duty nurse and GP. Patients were assessed individually according to the risks they presented with and changes made as appropriate to their care plans.

The practice employed a community nurse practitioner to allow the skills that this type of nurse provides to be delivered in patients' homes and local care homes for acute and pre-planned visits. The community nurse practitioner provided weekly ward rounds in local nursing homes and undertook medication reviews and dementia reviews for these patients. Outcomes were coordinated with multidisciplinary reviews to deliver the most appropriate care. This member of staff would also organise GP reviews for palliative care patients.

Nurses in the practice were trained on site for further skills such as ear syringing and child immunisation. The process for this was that nurses would shadow an existing competent colleague. Following this they would go on a course to learn the skill and then come back to the practice to perform the skill under supervision. Once deemed competent they would be able to perform these interventions by themselves. This process was evidence of a thorough assessment to enable clinicians' competencies in specific skills.

The same day clinic had a clinical supervision structure of daily de-brief sessions and weekly 1:1 meetings between a GP and a nurse during which patient scenarios were discussed along with blood results and care plans.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice actively ran regular searches using their computer system and the quality and outcomes framework (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). to help them to manage their performance in the diagnosis and treatment of common chronic conditions and to assess their quality and productivity. Minutes of meetings confirmed this was discussed on a regular basis in the practice.

The practice showed us ten clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit done on antibiotic prescribing had led to reflection for individual high prescribers in the practice on the prescribing formulary. Other examples included audits around gastroscopy and incretins (drugs that can help diabetics to better manage their condition).

Good

Are services effective?

(for example, treatment is effective)

GPs maintained records showing how they had evaluated the audits and documented the success of any changes. Following clinical audit cycles we saw that the outcomes had been discussed, shared and agreed at clinical meetings and the practice was able to demonstrate the learning and changes following the initial audit.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice achieved 85.7% of the total QOF target in 2014-15, which was below the national average of 93.5%.

Specific examples of the practice's QOF included:

- Performance for cancer related indicators was better at 100% than the national average of 95.5%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was lower at 81.1% than the national average of 83.8%.
- Performance for mental health related QOF indicators was lower at 73.6% than the national average of 90.4%.
- Performance for palliative care related QOF indicators was better at 100% than the national average of 96.7%.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. For example, we saw that the practice had a register of patients with a learning disability, mental health condition and a register of vulnerable adults. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review. At the time of our inspection the practice had 52 out of 76 mental health patients on a care plan. At the end of 2014-15 the practice had 39 out of 82 patients with learning disabilities on a care plan. The practice was looking to improve these figures by planning better rota capacity with more appropriately trained clinicians.

The practice had implemented systems for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, and the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. At the time of our inspection 101 patients out of 109 on this register had a care plan in place.

The practice offered a virtual clinic for patients with chronic diseases. This involved either a healthcare team member or the patient themselves monitoring vital signs, for example blood pressure. The results were then managed via a computerised protocol to determine the need for clinical intervention. Telephone consultations would be made with the patient to discuss next steps as necessary The practice informed us that if patients were unhappy with this process alternatives would be offered

The practice provided on-site anti-coagulation services to approximately 600 patients across the area it served.

Effective staffing

Practice staffing included medical, nursing, managerial, dispensary and administrative staff. We reviewed training records and saw that all staff were up to date with mandatory training except for basic life support. We were informed that this training was being addressed and it was overdue due to the resignation of the trainer from the practice.

We noted a good skill mix amongst the staff with a variety of special interests amongst the GPs including dermatology, family planning and acupuncture. The practice also employed a community nurse practitioner to allow the skills that this type of nurse provides to be delivered in patients' homes and local care-and nursing homes.

All GPs were up to date with their annual continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Most staff undertook annual appraisals that identified their learning needs and from which action plans were documented. Appraisals for non-clinical and dispensary staff were up to date. Appraisals for the nursing staff were overdue. These were not completed within the last 12 months at the time of our visit, with the exception of three nurse practitioners. The practice explained that the nurse appraisals were overdue due to the scale of nurse recruitment since December 2014 during which eight new nurses were employed with a further three planned in the near future. The new nurses had required training for their

Good

Are services effective?

(for example, treatment is effective)

new roles as provided by the GP and nurse manager. These would normally undertake the nurse appraisals and as such a delay had occurred in this process. There was planning in place for appraisals to commence again in August 2015 and the practice explained to us that they planned to bring in a formal appraisal process through the use of a nurse revalidation programme. The practice ensured us regular discussion and assessment had taken place with the nursing team but this merely was not formalised into an appraisal process.

The nurses and doctors we spoke with expressed that they felt supported by the other clinicians on site.

The practice nurses had been provided with appropriate and relevant training to fulfil their roles. Our interviews with staff confirmed that the practice was proactive in providing training and additional courses.

The practice linked specialised training in for example chronic diseases, for clinical staff to an increase in basic salary. Such a system was not in place for non-clinical staff.

We were told that staff were provided with an annual training budget the equivalent of two weeks wages per year. This allowed staff to seek development training they felt beneficial for their personal and the practice's development. This resulted in benefits to the patients as nurses were able to deliver a growing variety of skills.

Working with colleagues and other services

The practice worked with other services to meet patients' needs and manage complex cases, for example we saw evidence of referrals to district nurses for matters such as phlebotomy and dressings. One of the GPs was given protected time to ensure all referrals were dealt with appropriately. Internal referrals could be made for cardiology, dermatology and respiratory related illness due to the specialism being available with the GPs in the practice.

There were clear procedures for receiving and managing both written and electronic communications in relation to patients' care and treatment. Correspondence including test and X ray results, letters including hospital admissions and discharges, out of hour's providers and the 111 summaries were reviewed and acted upon on the day they were received by a duty team of nurse and GP.

The practice held daily coffee breaks with staff which allowed for informal opportunities to discuss patients' care and treatment and seek advice from colleagues.

The practice held monthly multidisciplinary (MDT) team meetings to discuss the complex needs of patients. These meetings were attended by other services such as community matrons, district nurses and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. Decisions about care planning were documented in a shared care record. There was a comprehensive system for managing results and discharge summaries and updating patient records and repeat medicines.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the out-of-hours services.

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.

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 provided evidence where this was escalated to multidisciplinary discussion.

There was a consent policy for staff to refer to that explained the different types of consent that could be given. Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff

Good

Are services effective?

(for example, treatment is effective)

administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent.

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). 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).

Health promotion and prevention

There was a wide range of information leaflets about health promotion and healthy lifestyle choices available within the waiting rooms where patients could see and access them and also on the website. We saw information about mental health, domestic violence advice and support that was prominently displayed in waiting areas with helpline numbers and service details. There was information and guidance available on diet, smoking cessation and alcohol consumption. There was information available about the local and national help, support and advice services. This written information was available in English and various other languages.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. Nurse led clinics and pre-bookable appointments were available including family planning and diabetic clinics. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

- The flu vaccination rate for the over 65s was 73.9%, above the national average of 73.2%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 94.5% to 97.2% and five year olds from 83.8% to 95.9%. These were generally in line with local averages.

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 GP survey published in July 2015. The evidence from these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. The national GP patient survey sent 314 surveys to patients and there had been a 34% response rate. Results showed the practice was rated at 92% for patients who rated the practice as good in comparison to the local average of 86% and the national average of 85%.

The practice was generally in line with the national averages for its satisfaction scores on consultations with doctors and nurses:

- 88%, compared to 89% nationally, of practice respondents said the GP was good at listening to them.
- 90%, compared to 90% nationally, said the nurse was good at listening to them.
- 84%, compared to 87% nationally, said the GP gave them enough time.
- 94%, compared to 92% nationally, said the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We collected 15 comment cards; all of these cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. Two cards contained comments around the difficulty of obtaining an appointment.

We also spoke with seven patients on the day of our inspection. All the patients we spoke with told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

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. To aid this, music was played in the waiting areas.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk, which helped keep patient information private. The practice informed us a private room to discuss confidential matters would always be available for patients if requested. The practice had a call centre which patients could call into at any time to obtain test results. This was located away from the reception and public areas and therefor was confidential. Additionally, 89% of patients said they found the receptionists at the practice helpful compared to the national average of 87%.

Care planning and involvement in decisions about care and treatment

The results from the 2015 National Patient GP survey which we reviewed showed that patients' responses were in line with national averages to questions about their involvement in planning and making decisions about their care and treatment. For example, 88% (compared to the national result of 86%) of practice respondents said the GP was good at explaining tests and treatments and 79% (compared to the national result of 81%) that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to, and supported by, staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that staff were caring, took their concerns seriously and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards also reflected these views.

Patient information was available in different languages on the practice website through a 'translate' facility; an interpreter service was advertised on the information screen in the waiting room

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

The patient survey information we reviewed showed patients were overall positive about the emotional support provided by the practice and rated it well in this area. For example:

87% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.

87% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received highlighted staff responded compassionately when they needed help and provided support when required.

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

Notices and information screens in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted clinicians if a patient was also a carer. The practice offered flu vaccinations to carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with who were deemed vulnerable. These registers were used to monitor and respond to the changing needs of patients. Patients on these registers were allocated extra appointment time if needed.

The practice utilised an electronic medical records system to record and collect information regarding patients. This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care, vulnerable adults or those patients who were caring for others.

The practice promoted independence and encouraged self-care for patients through the provision of printed and website information about healthy living.

Care and support was offered on site and local care-and nursing homes to ensure that the needs of these patients were identified and met. These locations were attended by the doctors and nurses on a responsive and pro-active basis.

The practice had been particularly active in identifying those patients who were at risk of unplanned admission to hospital and who had tailored, individual care plans. The patients in this group were recorded on a register and the practice had a system in place for their care plans to be managed during monthly multi-disciplinary team (MDT) meetings. This enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including collaboration with local care-and nursing homes.

A home delivery service was available for medication from the dispensary and an on-site associated pharmacy.

The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Patients recorded they were happy with the care and treatment they received. These findings were also reflected during our conversations with patients during our inspection.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of vulnerable adults. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review.

The practice was housed in an old building which limited the ability for access to all areas. Clinical treatment rooms were based over several floors and there was no lift. We saw that the premises' ground floor was configured in a way that enabled patients in wheelchairs to access ground floor consulting rooms. Patients with specific disabilities were identified on the practice's computer system and were offered additional support such as ground floor consultations or double appointments.

We saw that the practice website had a translation facility which meant that patients who had difficulty understanding or speaking English could gain online access to information about the practice. The practice had access to the use of translation services if required. There were three multi-lingual (eastern European) speakers in the patient's services team and a pharmacist who spoke four languages and could assist if necessary. A hearing loop was available in the practice to support patients with hearing loss.

The practice provided equality and diversity training. Staff we spoke with confirmed that they had access to the equality and diversity training and all staff we spoke with had completed this.

Access to the service

GP appointments were available Monday to Thursday between 08:00 and 20:00 and Friday from 08:00 until 18:30.

The practice operated an appointment system which offered advanced appointment booking, same day clinics, telephone triage appointments, home visits and several chronic disease clinics, for example for diabetes and asthma patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. Repeat prescriptions could be ordered online.

The practice used a same day clinic system for on the day appointments. This was a service that existed of four nurses (trained in assessment and management of minor illness, with history taking and examination) seeing patients, with one dedicated GP available for the nurses to call upon if required. This approach resulted in a significant increase in the amount of patients that could be seen who had the need for an on-the-day appointment. For example, where a GP would have been able to see 12 patients in a 2-hour session (at 10 minute appointments), the same day clinic allowed up to 48 patients to have access to the GP (albeit for a reduced amount of time) when supported by a team of four nurses. This had increased the number of patients that could be seen at an on the day appointment to 500 a week. The practice had set a target to increase this to 750 per week. One of the GPs confirmed to us that this approach was taken in consultation with the Royal College of Nursing (RCN). The practice advised us that at the time of our inspection there was a referral rate of approximately 75%, which meant that one in four patients were dealt with entirely by the nurse, without intervention of a GP. This allowed the GP to spend more time with those patients who needed it, or to deal with tasks in a more timely fashion.

The practice was in the process of applying the same model to be able to deal with conditions that required a follow-up but this was not yet in place at the time of our inspection.

When we reviewed the appointment system the wait for a routine appointment with a GP was two weeks at the time of our visit.

Patients were usually allocated standard appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs.

Patients requiring so could receive home visits. The practice employed a community nurse practitioner to manage these consultations alongside the GPs. Patients who were housebound or with limited mobility could also receive home visits and these were identified on the patient record system.

The patient survey information we reviewed showed patients did not always respond positively to questions about access to appointments. Overall they rated the practice as follows in these areas:

- 96% of respondents say the last appointment they got was convenient compared to the CCG average of 93% and national average of 92%.
- 65% described their experience of making an appointment as good compared to the CCG average of 77% and national average of 74%.
- 79% said they usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 65% and national average of 65%.
- 51% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. This was managed by the practice manager and/or the senior clinician who either passed the complaint to the staff member involved or dealt with it them. The practice made contact with patients who had concerns. The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology. The practice investigated complaints and kept a register of all complaints. This included actions taken as a result and learning from the complaints. The practice received 66 complaints last year, of which the practice had upheld 29 which were dealt with appropriately. We saw a summary which included reporting on the nature of the complaint and the findings. The summary defined trends such as complaints around the premises, treatment and clinical complaints and complaints related to staff

Good

Are services responsive to people's needs?

(for example, to feedback?)

attitudes. The practice was able to describe changes to services which were made a result of complaints and feedback. For example, a member of staff had received extra training around prescribing processes.

We saw that information was available to help patients understand the complaints' system on the practice's website. We did not see information displayed in the waiting areas of the practice but when patients requested the information at the reception desk they were provided with an information sheet and formal complaints form. Patients we spoke with were not always aware of the process to follow if they wished to make a complaint.

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. The vision was embedded around managing continuously rising demand and ensure commercial viability of the practice to be able to continue to deliver care throughout patients' lifetimes. The practice visualised itself to be well led to ensure strategic goals would be achieved.

Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these.

Governance arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear and accessible to staff. Staff told us that they were aware of their roles and responsibilities within the team. Some members of staff had lead roles, these included infection control and safeguarding. There was an atmosphere of teamwork, support and open communication.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for the practice nurse and health care assistant team and a lead diabetic nurse. Staff we spoke with were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. GPs all had different special interests, for example dermatology and diabetes.

There were policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working in the practice. The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance.

The practice had a programme of thorough clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken and drive improvements. These included prescribing and infection control.

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

Leadership, openness and transparency

Decision making and communication across the workforce was structured around key, scheduled meetings. Partner meetings covering general aspects of general practice took place weekly. Significant event meetings took place every month. The practice held monthly palliative care meetings and weekly meetings took place in the nursing team. The administration staff held meetings on an ad-hoc and as required basis. Following meetings information would be distributed to absent staff. The practice also attended prescribing meetings and monthly meetings with the local commissioning group. The dispensary held regular meetings also.

Multidisciplinary team (MDT) meetings took place monthly; these meetings were coordinated by an area MDT coordinator and were attended by the practice and community services staff.

In addition to staff meetings, the practice featured a daily, informal coffee meeting that took place for a short time each morning. All clinical staff attended. Any incidents and concerns arising from the previous day or morning's work were discussed and dealt with immediately or escalated for further investigation. The GPs also told us that daily lunch time provided a forum to engage for all off the staff.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through a patient reference group (PRG), surveys and complaints received. The PRG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PRGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

The practice had a virtual PRG which existed of 77 members according to the website. We met with two representatives of the PRG from a limited variety of population groups; they were actively trying to recruit more

Are services well-led?

Good

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

members. The representatives were positive about the practice stating they felt positive about their involvement in making decisions about their care and claimed the standard of care they received was excellent overall. This was echoed by other patients we spoke with on the day. There was general agreement amongst the patients we spoke with that routine appointment booking with their own GP could prove challenging. However, every patient we spoke with claimed urgent appointments were always available.

Staff we spoke with told us they felt happy they could raise their concerns with their respective manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to staff development. For example, through the use of daily coffee breaks which were used to discuss clinical cases and daily lunch during which all staff could engage with each other.

The practice linked specialised training in for example chronic diseases, for clinical staff to an increase in basic salary. Such a system was not in place for non-clinical staff.

We were told that staff were provided with an annual training budget the equivalent of two weeks wages per year. This allowed staff to seek development training they felt beneficial for their personal and the practice's development.