Dr JA Sutherland's Practice

Quality Report

Killamarsh Medical Practice
209 Sheffield Road
Killamarsh
Sheffield
S21 1DX
Tel: 0114 2510002
Website: killamarshmedicalpractice.co.uk

Date of inspection visit: 14 December 2015
Date of publication: 11/02/2016

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 Dr JA Sutherland's practice (Killamarsh Medical Practice) on 14 December 2015. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events, and we saw evidence that learning was applied from events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment, and clinicians had lead areas of responsibility.
- Feedback from patients about their care was consistently and strongly positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP, and usually this was with a GP of their choice. Routine appointments could often be booked on the day and if not, they were available within two days. Urgent appointments were available the same day, and the practice offered additional appointments on a sit and wait at the end of each morning surgery.
- The practice offered a minor injuries service and data demonstrated that 28 of 30 patients who had accessed this service since April 2015, had been treated without the need for referral to another unit such as the Accident & Emergency (A&E) department.
- The practice used clinical audits to review patient care and took action to improve services as a result.
- The practice had good facilities and was well equipped to treat patients and meet their needs. This was to be enhanced by an extension, including seven new consulting rooms, which was under construction at the time of our inspection.
- The practice worked well with the wider multi-disciplinary team to plan and deliver effective

Summary of findings

and responsive care to keep vulnerable patients safe. This approach had impacted on unplanned hospital admissions and attendance at Accident and Emergency.

- There was a clear leadership structure and staff felt supported by management.
- The practice reviewed feedback from patients acted upon it. For example, further to comments made on the NHS Choices website, the practice ensured that a member of the reception team was always placed at the front of the reception desk during opening hours.
- 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. For example, as part of the extension to the building, the access road would be widened with a footpath to aid patient access from the car park.

We saw two areas of outstanding practice:

- A community pharmacist visited weekly and worked with the practice and the CCG medicine management technician on a variety of prescribing matters. The pharmacist reviewed spirometry results (spirometry is a test used to help diagnose and monitor some lung conditions by measuring how much air can be expelled in one forced breath) and reviewed patients with diagnosed lung disease for advice and medication reviews. The pharmacist had also audited patients with atrial fibrillation to determine if anti-coagulation therapy was required in line with recognised guidance.Approximately 20-25 patients were seen by the pharmacist each month.
- The practice employed their own community matron and care co-ordinator who managed patients by developing individualised care plans involving the wider health and social care team. This helped to keep patients safe in their own home (and in care homes), and also facilitated earlier hospital discharges. Alongside the practice's proactive approach in providing good access to GP appointments, a measurable impact was seen in the lower attendance at out of hours and A&E services, and the lower rates of unplanned hospital admissions for this 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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure actions were taken to improve safety in the practice. For example, following the identification of a discrepancy on a prescription, it was noted that medicines had not been updated in accordance with advice from the hospital. This led to a more thorough review of hospital letters to ensure all actions were completed.
- When there were unintended or unexpected safety incidents, people received support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- The practice had effective recruitment procedures in place to ensure all staff had the necessary skills and qualifications to perform their roles, and had received the appropriate pre-employment checks.
- Risks to patients and the public were assessed and well-managed including procedures for infection control and other site-related health and safety matters. Risks to vulnerable patients with complex needs were monitored by multi-disciplinary team meetings to provide holistic care and regular review.
- Medicines, including vaccines and emergency drugs, were stored safely and appropriately with good systems to monitor and control stock levels.
- The practice had effective systems in place to deal with medical emergencies.
- The practice ensured staffing levels were sufficient at all times to respond effectively to patient need.

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. The practice had achieved an overall figure of 100% for the Quality and Outcomes Framework 2014-15. This was 1.9% above the CCG and 6.5% above the national averages.

Summary of findings

- Staff assessed needs and delivered care in line with current evidence based guidance. We saw that the clinical team had just reviewed new NICE guidance on menopause.
- Clinical audits demonstrated quality improvement, and we saw an example of a full cycle audit that had led to improvements in prescribing and documentation of clinical features for patients with acne.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. GPs had specific areas of interest including diabetes and dermatology, and acted as a resource for their colleagues.
- A community pharmacist provided weekly input to the practice including the provision of medicine reviews and advice for patients with chronic lung disease.
- Annual appraisals and personal development plans were in place for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs, in order to deliver care more effectively. For example, the community matron met weekly with the wider health and social care team to plan and oversee care for vulnerable patients. This helped manage the number of unplanned hospital admissions at 77 per 1,000 population compared to a national average of 90.
- The practice had lower usage of Accident & Emergency (A&E) and out of hours services as a result of good GP access including a minor injuries service.Figures for 2014 showed A&E attendance at 219 per 1,000 patients compared to national average of 329. Out of hours attendances for 2014-15 recorded 112 contacts per 1,000 population which was almost 50% lower than the CCG average figure of 214.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed that patients rated the practice in line with CCG and national averages in respect of care. For example, 90% said the GP was good at listening to them compared to the CCG average of 92% and the national average of 89%.
- Patients we spoke with during the inspection and feedback on our comments cards indicated they were treated with compassion, dignity and respect and felt involved in decisions about their care and treatment.

Summary of findings

- The practice adopted a 'kid gloves' approach in dealing with vulnerable patients. This ensured their individual needs were accounted for in circumstances such as late arrival for an appointment.
- Information for patients about the services available was easy to understand and accessible.
- We observed that staff treated patients with kindness and respect, and maintained confidentiality.
- GPs regularly visited end of life patients and were happy to be contacted outside of normal hours by carers and nursing staff to ensure the patient was cared for effectively.
- Views of external stakeholders were very positive and aligned with our 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 to secure improvements to services where these were identified. For example, the practice had submitted a successful bid to expand its premises to support its vision for the future, which was in accordance with the CCG's 21st century model of care to provide services closer to patients.
- 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. For example, the practice had installed new and improved signage at the entrance of the practice further to comments received from the patient participation group (PPG).
- People could access appointments and services in a way and at a time that suited them. Urgent and routine appointments were available on the day. All GP appointments were available to book on-line.
- Comment cards and patients we spoke to during the inspection were very positive about their experience in obtaining a routine appointment. This was reinforced by the national GP survey in July 2015 which found 84% patients described their experience of making an appointment as good. This was in comparison to a CCG average of 76% and a national average of 73%.
- The practice had good facilities and was well equipped to treat patients and meet their needs, and this would be enhanced further by the extension under construction.

Summary of findings

- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff to improve the quality of service. An example of this included ensuring a receptionist was always available at the front of the reception desk throughout opening hours, in response to comments made on the NHS Choices website.
- All patients had been allocated an accountable GP to oversee their care.

Are services well-led?

Good

The practice is rated as good for being well-led.

- It had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. 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 meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The practice sought feedback from staff and patients, which it acted on.
- The PPG was active and influential in informing practice developments, for example the installation of automatic entrance doors.
- There was a strong focus on continuous learning and improvement at all levels.
- All staff had received inductions and had received regular performance reviews, and attended staff meetings. There was a high level of staff satisfaction, and this was supported by low staff turnover.
- Effective succession planning ensured continuity of service and practice development.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. Care plans were in place for older patients with complex needs.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice provided primary medical services to residents at two local care homes. Managers at these homes were very happy with the level of care provided by the GPs, and described the relationship with the practice as extremely positive. They told us the practice were very responsive and caring, that they accommodated the individual needs of their patients, and that the practice achieved good outcomes for their residents.
- 80% of over 75s had received an annual health check in the last 12 months.
- Flu vaccination rates for the over 65s were 85.9% which was higher than the national figure of 73.2%.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis and heart failure were in line with or above local and national averages

People with long term conditions

Good

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

- All patients with a long-term condition had a named GP and nursing staff had lead roles in chronic disease management. For those patients with the most complex needs and associated risk of hospital admission, the practice team worked with health and care professionals to deliver a multidisciplinary package of care.
- Indicators to measure the impact of the management of diabetes were higher than local and national averages. For example, the percentage of patients on the practice register for diabetes with a record of a foot assessment in the preceding 12 months at 94% was approximately 5% above both local and national averages.
- A practice nurse provided initiation of insulin for patients with diabetes.

Summary of findings

- Patients with diabetes are referred into the 'Diabetes and You Programme' to provide patients with advice and education to help manage their condition.
- QOF indicators for asthma were higher than CCG and national averages. For example, 86.7%of patients with asthma received a review in the preceding 12 months, compared to the CCG and national averages of 74.2% and 75.3% respectively.
- 58% patients on the practice long term condition registers had received a structured annual review during 2014-15 to check that their health and medicines needs were being met.

Families, children and young people

Good

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

- Urgent appointments and a walk in service was available every day to accommodate children.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances, or did not attend for planned hospital appointments on more than two occasions. We were informed of examples when practice staff had referred children where safeguarding concerns had been identified. Effective liaison was in place between the practice and the health visiting team.
- Immunisation rates were relatively high for all standard childhood immunisations. For example, vaccination rates for children under two years old was 100% compared against a CCG average ranging from 97.8 to 98%.
- 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.
- The practice's uptake for the cervical screening programme was 86.1% which was above the CCG average of 83.9% and the national average of 81.8%.
- A midwife provided services from the surgery. Appointments with the practice nursing team were available outside of school hours, and the premises were suitable for children and babies. A designated children's play area was sited in the reception.
- The female GPs provided a service to fit coils and contraceptive implants. This service was provided at short notice and often within the initial consultation.
- A teenage youth clinic provided access to support with contraception, and chlamydia screening was offered.

Summary of findings

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. This included good access to appointments including telephone consultations.
- The practice was proactive in offering online services and all GP appointments were offered through the online booking system
- Health promotion and screening was provided that reflected the needs for this age group.

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. Homeless people could register with the practice, although there were none listed at the time of our inspection.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and informed patients how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice provided good care and support for end of life patients. Patients were kept under close review by the practice in conjunction with the wider multi-disciplinary team, and a GP informed us that additional visits had been provided at the weekend, or at night if a death certification had been required.
- The practice adopted an approach that they termed as 'kid gloves' for vulnerable patients and carers. This ensured that the practice took a more supportive approach with individuals in recognition of their condition or circumstances. For example, if they were late for their appointment time.
- The practice had carried out annual health checks for people with a learning disability, and 84% had attended for an annual review during 2014-15. It offered longer appointments for people with a learning disability.

Summary of findings

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).

- 89.9% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This compared to a CCG average of 83.6% and a national average of 84%
- The practice achieved 100% for mental health related indicators in QOF, which was 1.9% above the CCG and 7.2% above the national averages, although the rate of exception reporting was generally higher.
- 100% of patients on the practice's mental health register had received an annual health check during 2014-15.
- 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 and patients with dementia about how to access various support groups and voluntary organisations. Leaflets were available in the waiting area on a range of services available for patients and carers.
- It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support people with mental health needs and dementia.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2015. The results showed the practice was performing in line with local and national averages. 257 survey forms were distributed and 98 were returned, which was a 38% completion rate of those invited to participate.

- 93% of respondents found it easy to get through to this surgery by phone compared to a CCG average of 76% and a national average of 73%.
- 90% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 87% and a national average of 85%.
- 100% said the last appointment they got was convenient compared to a CCG average of 93% and a national average of 92%.
- 84% described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 90% of respondents found the receptionists at this surgery helpful compared to a CCG average of 89% and a national average of 87%.
- 76% usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 72% and a national average of 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 48 comment cards which were all positive about the standard of care received, other comments related to the ease in obtaining an appointment with a GP, and the high standards of cleanliness within the practice.

We spoke with nine patients and one relative during the inspection. All nine patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

Dr JA Sutherland's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a nurse specialist adviser, a practice manager specialist adviser and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr JA Sutherland's Practice

Dr JA Sutherland's practice is also known as Killamarsh Medical Practice and is located in North East Derbyshire. The practice serves the parish of Killamarsh and is situated close to Rother Valley Country Park between Sheffield, Chesterfield and Rotherham. The area was previously a thriving mining community but now many residents commute to Sheffield and other nearby towns for work. The practice was built in 1991 and is currently having a large extension of its premises built to accommodate increased patient numbers and demand for services, as well as for the predicted growth from new housing developments planned locally.

The practice is run by a partnership of five GPs (three male and two female). The practice has a full- time and a part-time practice nurse, and two health care assistants (HCAs). One of the HCAs also works as a care-cordinator. The practice also directly employs a part-time community matron. The clinical team is supported by a full-time practice manager and a team of eight administrative, secretarial and reception staff. The practice use funding provided by the CCG to contract a community pharmacist to work for one session each week.

The registered practice population of 9,114 are predominantly of white British background, and are ranked in the third least deprived decile. The practice age profile is broadly in line with national averages but has slightly higher percentages of patients aged 45-70 years old, and lower percentages of patients below the age of 15.

The practice opens from 8am until 6.30pm Monday to Friday. GP morning appointments times are available from 8am to 10.20am, and afternoon surgeries run from 4pm to 6.20pm, apart from Wednesday afternoons when there are no booked GP surgeries although urgent and essential care is still provided.

The practice supports medical students as part of their eight week placement in general practice. It does not act as a training practice for GP registrars.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed patients are directed to Derbyshire Health United (DHU) via the 111 service.

The practice holds a Personal Medical Services (PMS) contract to provide GP services which is commissioned by NHS England. A PMS contract is one between GPs and NHS England to offer local flexibility compared to the nationally negotiated General Medical Services (GMS). The PMS contract offers variation in the range of services which may be provided by the practice and the financial arrangements for those services. The practice also offers a range of enhanced services including minor surgery commissioned by their local CCG

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and North Derbyshire CCG to share what they knew.

We carried out an announced inspection on 14 December 2015 and during our inspection:

- We spoke with staff including GPs, the community matron, practice nurses, the practice manager and a number of reception and administrative staff. In addition, we spoke with a representative of the district nursing team, managers at two local care homes, and pharmacists regarding their experience of working with the practice team. We also spoke with patients who used the service, and representatives from the practice patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 48 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

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

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

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

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- 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.
- The practice carried out a thorough analysis of the significant events and reviewed these at clinical staff meetings which were held each month.

We reviewed incident reports and saw minutes of a meeting held in September 2015 to review the four significant events over the preceding 12 month period. This included the identification of any learning points required to improve safety in the practice and the actions that had been taken to achieve this. For example, a vaccination which had just passed its expiry date was administered to a patient. This had no clinical harm upon the patient but the practice used the incident to ensure that staff were retrained on administering vaccines and that stock checks were more robust and in accordance with the practice procedure.

When there were unintended or unexpected safety incidents, people received reasonable support, truthful information, an apology and were told about any actions taken to prevent the same thing happening again.

The practice had a process to review and share any drug alerts received via the Medicines Health and Regulatory Authority (MHRA). However, the procedure of auditing individual patients to ensure effective action had been taken following the alert was not routinely undertaken, although the practice stated they would introduce a revised process after this had been highlighted to them. This also applied to the processes for drugs that required ongoing monitoring such as ACE inhibitors (used to lower blood pressure).

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about an individual, and we were given examples of incidents where staff had reported their concerns to protect patients. There was a lead GP for safeguarding who attended quarterly safeguarding meetings with the health visitor. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to safeguarding level 3 and we saw evidence of their certificates.
- A notice in the waiting room advised patients that nurses would act as chaperones, if required. Nursing staff usually acted as chaperones and were trained for the role and had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Occasionally, a member of the administration team acted as a chaperone and whilst they did not have a DBS check, an appropriate risk assessment had been undertaken to ensure that systems were in place to manage this procedure safely.
- The practice maintained appropriate standards of cleanliness and hygiene, and we observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken specific training to support this aspect of their role. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice employed their own cleaning staff who worked to specific cleaning schedules that were monitored by the practice.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to

allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccinations.

- We reviewed five staff files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- The practice had a system to manage incoming correspondence and ensured that any actions, such as a change to a patient's medicines, were completed promptly. We observed that the system was safe. However, the process did not demonstrate a clear audit trail which could be achieved by utilising the computer's task function to greater effect. The practice stated they would review their current approach.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. Health and safety audits for the site were completed quarterly. There was a practice health and safety policy available, and a Health and Safety Executive (HSE) poster was on display in line with legal requirements. The practice had up to date fire risk assessments and carried out regular fire drills. An audit on fire compliance was undertaken by the Derbyshire Fire Service in September 2015 which advised on some minor enhancements which the fire officer confirmed would be superceded by the installation of a new fire alarm for the building in early 2016 as part of the site expansion. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as manual handling, lone working and legionella.
- 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 all the different staffing groups to ensure that enough staff were on duty, and we saw examples of how the nursing team worked flexibly to ensure adequate cover was available. Extra GP sessions were scheduled in to manage demands for appointments. For example, an additional session would be provided on a Wednesday afternoon following a Bank Holiday. All partners worked eight sessions over four days which afforded the opportunity to increase up to ten sessions to cover holidays and sickness.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- We saw evidence that all staff had received annual basic life support training
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- We reviewed an incident in which a patient had a severe anaphylactic shock after receiving a certain medication. This demonstrated that the practice responded effectively in administering emergency drugs and providing care to the patient to keep them safe whilst waiting for the ambulance to transfer the patient to the hospital.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan was reviewed annually, most recently in November 2015, and included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met people's needs.
- The practice monitored that these guidelines were followed through clinical discussions and audit. We saw notes from a recent clinical meeting where NICE guidance on diagnosis and management of menopause, published in November 2015, had been reviewed and discussed by the GPs.

The practice reviewed benchmarking data provided by their CCG to monitor and improve patient care and safety. For example, the practice had been identified as having the lowest prevalence for heart failure in their CCG. This led to an audit of patients which demonstrated that the practice were screening for heart failure appropriately. This was done on the day that the issue was highlighted to the practice and showed a proactive approach in responding to information to ensure patient safety and effective care.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available, with 11.8% exception reporting (which was in line with the CCG average, and slightly above the national average of 9.2%). The exception reporting figure is the number of patients excluded from the overall calculation due to factors such as non-engagement when recalled by the practice for reviews. A lower figure demonstrates a proactive approach by the practice to engage their patients with regular monitoring to manage their conditions. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed;

- Performance for diabetes related indicators was 100% and this was better than the CCG average of 96.7% and the national average of 89.2%, although exception reporting rates for the indicators were generally higher.
- The percentage of patients with hypertension having regular blood pressure tests was 85.7% which was comparable to the CCG and above the national average of 83.6%, with slightly higher exception reporting rates.
- Performance for mental health related indicators at 100% was above the CCG average of 98.1%, and above the national average of 92.8%. Exception reporting rates were higher than CCG and national averages.
- The number of patients diagnosed with dementia who had a face to face review in the preceding 12 months was 89.9%. This was higher than the CCG average of 83.6%, and above the national average of 84%. Exception reporting rates were lower than both CCG and national averages.
- Asthma related indicators achieved 100%, which was approximately 2.5% above both CCG and national averages. This was achieved with lower rates of exception reporting.

Prescribing of medicines including hypnotics and specified broad spectrum antibiotics was significantly lower than national averages in line with NICE guidance, and the practice worked with the CCG management technician to ensure cost effective prescribing. Prescribing costs were lower than CCG and national averages.

Clinical audits demonstrated quality improvement.

- There had been five clinical audits completed in the last year, two of these were completed audit cycles where the improvements made were implemented and monitored. For example, the practice had completed a full cycle audit on gestational diabetes (this is a type of diabetes that affects some women during pregnancy). Patients should have regular screening to assess any risk of developing type 2 diabetes following birth. The outcome of the audit was to establish a more robust mechanism to identify patients and ensure that follow up blood tests were done. Visiting medical students were also involved with practice audits.

Good

Are services effective?

(for example, treatment is effective)

- Findings were used by the practice to improve services. For example, positive outcomes were achieved as a result of a full cycle audit of patients being treated for acne. This was initiated as a result of new acne care pathway introduced by the CCG to ensure consultations were documented in accordance with the guidance and that antibiotic prescribing was appropriate. The second cycle demonstrated that there had been an 18% reduction in antibiotic prescribing in those patients identified within the audit, and the associated documentation of clinical findings had improved. A further audit was planned in another 12 months to ensure results were maintained, and improved further if possible.
- The practice participated in CCG medicines audits. For example, Guidance on Risk Assessment and Stroke Prevention for Atrial Fibrillation (GRASP) is a tool used in primary care to help assess the risk of stroke related to atrial fibrillation and the effective management of atrial fibrillation in patients. The pharmacist had undertaken a GRASP-AF audit which had identified 77 patients at high risk of atrial fibrillation and these had been reviewed leading to some patients being prescribed appropriate anti-coagulation therapy.

The practice had lower usage of out-of-hours services and lower rates of attendance at A&E. This was achieved by the good access offered by the practice and the facility to see walk-in patients including those presenting with a minor injury. From April 2015, 30 patients had attended as part of the walk-in service with minor injuries and 28 of these had been dealt with by the practice, with only two patients being re-directed elsewhere for treatment. A&E attendance was the 11th lowest of 36 practices within the CCG and had consistently achieved an A&E attendance rate below the CCG average for the last three years. Figures for 2014 showed A&E attendance at 219 per 1,000 patients compared to national average of 329. Out of hours attendances for 2014-15 recorded 112 contacts per 1,000 population which was almost half of the CCG average figure of 214 contacts per thousand population.

Effective staffing

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

- The practice had appointed their own community matron and care co-ordinator to manage the needs of more complex patients who were at risk of hospital admission. The lower usage of hospital and out of hours services demonstrated this was having an impact for patients. This initiative was funded by the CCG.
- A pharmacist worked at the practice for one session each week, supported by funding through the CCG. The pharmacist had completed extended and accredited training in chronic obstructive pulmonary disease (COPD), which is a collective term for disease affecting the lungs. The pharmacist reviewed the spirometry results of newly diagnosed COPD patients, and those who had received an annual review. Spirometry is a test used to help diagnose and monitor some lung conditions by measuring how much air can be expelled in one forced breath. The pharmacist saw approximately 20-25 patients with COPD each month to discuss their condition and prescribed any medications that were indicated, and these were approved by one of the GPs. Patients with atrial fibrillation were also seen by the pharmacist to discuss the benefits of anticoagulation therapy. Atrial fibrillation is an irregular and often abnormally fast heart rate, and the prescribing of anticoagulation medication can help reduce the prevention of blood clots which may be associated with the condition. Additionally, the pharmacist contributed to other medicines management work within the practice and worked in conjunction with the CCG's medicines management technician, for example, in reviewing hospital letter medication changes. The work helped to reduce the need to see a GP by providing access to specialist advice.
- The GPs had lead areas of specialist clinical interest including dermatology and rheumatology and acted as a resource for their colleagues. Each GP or the practice manager also had designated lead areas of responsibility including complaints and mental capacity.
- The practice had an induction programme for newly appointed members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff e.g. administering vaccinations and taking samples for the cervical screening programme.
- The community matron had an identified GP to act as a mentor. Other nurses were also able to access the GPs for guidance when required.

Good

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals and ongoing reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. All staff had had an appraisal within the last 12 months.
- Staff received training that included safeguarding, fire procedures, basic life support and information governance awareness. Staff had recently been provided with access to e-learning training and the practice manager had prioritised the modules for completion, with a plan to roll out other topics at a later date.In-house training was also organised where appropriate, such as basic life support training.

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 assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated. For example, a weekly multi-disciplinary team meeting took place including the practice's community matron with representatives from social services, mental health, district nursing and community physiotherapy. This meeting reviewed the needs of complex patients who were at risk of hospital admission, and aimed to care for patients in their own home and to provide the necessary support further to a hospital discharge. Emergency admissions for the practice were 77 per 1,000 population compared to a national average of 90 which showed that this was being managed well.

Monthly palliative care meetings took place to provide optimal care for those patients with end of life needs.

The practice provided primary care medical services to two local residential and nursing homes as part of a local enhanced service. We spoke to the managers at these homes who informed us that the practice were responsive to requests for visits. The managers stated the service received from the practice was excellent and that their staff were consulted about patients, and relatives were also invited to attend when appropriate to contribute to discussions about ongoing care. Quarterly meetings were also undertaken to review the provision of the GP input to the homes.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, and we saw evidence of completed MCA training by clinicians. A manager of a local care home informed us that the GPs had been involved in best interest assessments as part of the Mental Capacity Act, and Deprivation of Liberty (DoLS) assessments with their patients.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

Good

Are services effective?

(for example, treatment is effective)

- 86% patients aged over 16 who smoked had been offered smoking cessation advice.

The practice's uptake for the cervical screening programme was 86.1% (achieved with a lower exception reporting than average), and this was above the CCG average of 83.9% national average of 81.8%. 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. For example, breast cancer screening over the last 12 months achieved a 78% uptake, compared against a CCG average of 74% and a national average of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds was 100% compared against a CCG average ranging from 97.8 to 98%,and five year olds from 98% to 100%. Flu vaccination rates for the over 65s were 85.9%, (nationally this figure is 73.2%) and at risk groups 71.2% (significantly above the national average of 52.29%). This was the highest figure in the CCG for the over 65s, and the third highest for at risk groups.

Patients had access to appropriate health assessments and checks. The practice did not offer NHS health checks for new patients but did provide these for people aged 40–74. A total of 63% patients offered this service had received a health check since its introduction. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice had developed their own lifestyle information leaflet proving information on healthy eating, physical activity and smoking and alcohol advice. This contained telephone contacts for smoking cessation and the alcohol advice service, as well as the wellbeing worker attached to the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity 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 they could offer them a private room by the reception to discuss their needs.

All of the 48 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We also spoke with two members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was generally in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 88% said the GP gave them enough time
- 95% said they had confidence and trust in the last GP they saw
- 86% said the last GP they spoke to was good at treating them with care and concern
- 90% said the last nurse they spoke to was good at treating them with care and concern
- 90% said they found the receptionists at the practice helpful

Care planning and involvement in decisions about care and treatment

Patients told us that 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 86%.
- 78% said the last GP they saw was good at involving them in decisions about their care

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

Managers at care and residential homes covered by the practice told us the GPs treated their residents with care and respect, and were also happy to meet with relatives or carers to discuss the treatment being provided to individuals. The GPs visited routinely each week and would respond on the day to any identified urgent medical needs. Quarterly reviews were undertaken on all patients, and end of life care was well-managed for residents.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Good

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 0.64% of its patients as carers, which is slightly lower than the average figure of 1-2%. Written information was available to direct carers to support services available to them.

The practice managed end of life care in conjunction with the wider multi-disciplinary team. GPs regularly visited end of life patients and were happy to be contacted outside of normal hours by carers and nursing staff to ensure the patient was cared for effectively. Staff told us that if families had suffered bereavement, their usual GP would visit the relatives to offer condolences and support, or signpost to support services, if this should be required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. For example, the practice had successfully bid for an extension to their surgery which will provide seven additional consultation rooms.

- Appointments with the GP and nurse were easily accessible. Urgent appointments were available on the day, and routine appointments were often available either on the day or within two days. On the day of our inspection, a routine GP appointment could be booked the following day, and a nurse appointment was available the same day. If the appointments became full, patients could still attend and wait to be seen by one of the doctors on duty.
- The practice used a text reminder service for appointments and closely monitored it's did not attend (DNA) rates. It displayed the DNA rates in the waiting area and on the log-in screen so that patients could see the impact that non-attendance had for other patients and clinicians. Patients with repeated failed appointments received a letter to highlight the impact this had on others.
- The practice offered a minor injuries service and saw patients on the day. We observed this on the day of our inspection. This avoided patients having to attend the A&E department.
- The practice provided a range of services including INR monitoring (to monitor the use of warfarin for the management of blood clotting), travel vaccinations, family planning and teenage health clinics.

The practice also hosted other services for their patients on site. This included:

- Counselling and mental health talking therapies sessions were offered on site by two separate providers. This helped to facilitate timely access for patients to be seen at the earliest opportunity, and most patients were seen within two weeks of referral.
- The community midwife held two clinics at the practice each week.
- The district nursing team held daily clinics in the practice's treatment room which included the provision of dressings, and Doppler tests (a diagnostic test to assess blood flow).
- A health trainer provided advice on issues including weight management and smoking cessation on two days each week
- The alcohol and drug team provided a service on site each week. This was hosted by the practice and used by their own patients, and by others registered with neighbouring practices.
- An independent pharmacy was located on site which patients could access directly from the reception area. This had been developed as a 100 hour pharmacy to improve access to a local pharmacy for patients residing in the local area. Practice patients who opted to use this pharmacy could access their medications during the visit to the doctor's surgery. The pharmacist told us that the practice were proactive in the use of e-prescribing (a computer-generated electronic generation and transmission of the prescription directly to the patient's preferred pharmacy) and approximately 40% of the practice patients using the pharmacy were now using the technology.

Additionally:

- The practice referred some patients to a local GP with a specialist interest in dermatology to help reduce referrals to the hospital and provide local access to services.
- Home visits were available for patients who would benefit from these. There were longer appointments available for people who might require them, for example, patients with a learning disability
- We spoke to managers at two local care homes who informed us that the practice visited routinely on a weekly basis, and also would attend on the same day for any urgent needs.
- There were disabled facilities including ramped access, automatic entrance doors and disabled toilets. A disabled parking space was available outside of the practice, and designated disabled parking was to be provided as part of an ongoing site extension. The reception desk was not conducive for talking to patients in wheelchairs but this was to be addressed as part of the refurbishment work. A hearing loop was available but this was not being used to optimal effect; however

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice were receptive to the feedback given by a member of the inspection team and agreed to review this. Large print leaflets were available for those with a visual impairment.

- Translation services could be accessed if required for patients whose first language was not English. Information was displayed to advise patients about this.
- A wide range of patient information leaflets were available in the waiting areas and there were display boards providing information on asthma, the flu vaccination programme and the health promotion work provided by the visiting health trainer.
- The practice was having an extension built which would be followed by a refurbishment of the existing premises. This would create better facilities for patients and also provide the practice with the opportunity to host more services on site.
- We spoke with clinicians who worked with the practice, but were employed by different organisations, and they described the practice as being highly receptive to any suggestions they made, and that their interactions with the practice were consistently positive.

Access to the service

The practice opened between 8am and 6.30pm from Monday to Friday. GP appointments could be booked from 8am until 10.20am every morning, and from 4pm until 6.20pm each afternoon apart from Wednesday afternoon when only urgent or essential care was provided. All appointments were available through the on-line booking system, rather than specifically allocated slots. We spoke with a patient who attended the practice on the day of our visit who had booked their appointment on-line the previous day. In addition, pre-bookable appointments could be booked up to six weeks in advance for a GP, and appointments were available on the day for people that needed them.

The practice did not provide any extended hours opening. However, we found that access was managed extremely effectively and the feedback from patients was overwhelmingly positive regarding their experience of obtaining an appointment when they needed one.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages. People told us on the day of the inspection that they were able to get appointments when they needed them.

- 90% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.
- 93% of patients said they could get through easily to the surgery by phone compared to a CCG average of 76% and a national average of 73%.
- 77% of patients said they usually got to see or speak to their preferred GP compared to a CCG average of 60% and a national average of 60%.
- 84% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 76% of patients said they usually waited 15 minutes or less after their appointment time compared to a CCG average of 72% and a national average of 65%.
- 70% of patients surveyed felt they didn't normally have to wait too long to be seen compared to a CCG average of 63% and a national average of 58%.

In addition, 47% of the feedback received within the comments cards mentioned that access to a GP appointment was excellent. The practice had incorporated an additional question into their Family and Friends Test (FFT) since July 2015 to obtain more feedback on their opening hours due to the limited sample size of the national survey. This had showed 92 to 97.4% patients were satisfied with the opening hours over the last six months.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled complaints in the practice.
- We saw that information was available to help patients understand the complaints system within a patient feedback and praise leaflet available within the reception area, although the information was not clearly displayed on notice boards. The practice website also provided information on making a complaint.

We looked at four complaints received in the last 12 months and found these were dealt with in a satisfactory and timely way, and handled with an open and transparent

Good

Are services responsive to people's needs?

(for example, to feedback?)

approach. The practice also reviewed comments posted on the NHS Choices website and responded to these appropriately. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of the service. For example, in response to a complaint about delayed treatment, the practice acknowledged that they should be more proactive in providing explanations regarding the process of investigations and the potential timescales involved. The practice had reflected on the case and applied learning by ensuring greater communication with patients in such cases so that they are kept informed to help alleviate their 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 had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Business planning meetings were held annually, most recently in September 2015. We saw that comprehensive minutes had been produced from the meeting and an action plan had been developed and kept under review. The practice had secured funding for an extension through the Primary Care Infrastructure Fund by the submission of a comprehensive business case outlining the vision and aspirations for the practice.

The partners held a shared approach to managerial responsibilities by maintaining a flat management structure. Lead responsibilities for issues such as financial management were planned to be rotated to ensure all the partners developed their skills and knowledge in different areas of practice management.

There was a proactive approach to succession planning in the practice. When the senior partner retired recently, the GP worked as a salaried GP for a further six months to provide transitional advice and support to another partner with regards the financial and business management aspects of the practice.

The GP partners all worked full-time within the practice and limited their outside commitments to focus on the delivery of the core service. This approach was highly effective in minimising the need to use locum GPs, thereby facilitating access and ensuring continuity for patients. However, the GPs still engaged in wider meetings with their CCG where this was necessary (for example, the practice hosted the locality prescribing meetings) but tried to limit attendance at externally held meetings to one GP, who would then feedback to the rest of the practice team.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the business plan and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities
- A range of practice policies were implemented and readily available to all staff
- A comprehensive understanding of the performance of the practice, and the utilisation of comparative data across the CCG to review outcomes whenever this was indicated.
- The practice engaged in annual Support for Quality Improvement (SQI) meetings with their CCG which facilitated discussion and analysis of information including GP referrals, emergency admissions and medication reviews. We saw minutes from November 2014 which were positive and reflected on achievements from the previous year including the hosting of multi-disciplinary meetings for patients with multiple and complex health and social care issues.
- A programme of clinical audit was used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks and implementing mitigating actions. This was under constant review and we saw evidence of this in how issues such as a new temporary fire protocol had been implemented as part of the current building extension.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners and the practice manager were visible in the practice and staff told us that they were approachable and took the time to listen to all members of staff.

When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and an apology

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us that the practice held clinical and nurse team meetings monthly, and meetings for clerical and administrative staff (which included a GP) were normally held bi-monthly, and we saw evidence of well-documented minutes from these meetings.

Are services well-led?

Good

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

- Staff told us that there was a blame free and open culture within the practice and that they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. The team felt included in discussions about how to develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- Staff turnover was low indicating staff were happy to work at the practice. The practice had also recruited a new full-time GP partner earlier this year despite the current difficulties being experienced with GP recruitment.

There was a strong community spirit in the area and this was reinforced by our discussions with staff, patients and others including the care homes managers. The practice told us that when the independent pharmacy was built on site they approached the local youth club who voluntarily decorated the pharmacy for the practice. The practice was well integrated within their community.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- It had gathered feedback from patients through the patient participation group (PPG) and from patient feedback including family and friends test results, the NHS Choices website, patient praise and comments leaflets, and from complaints that had been received. There was an active PPG which met on a six monthly basis and submitted proposals for improvements to the practice management team. For example, automatic entrance doors had been installed, new signage had been placed on the front of the practice, and a new footpath would be provided from the car park as part of the ongoing extension build. The PPG did not have any information on display to promote their work or encourage new members to join.
- 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. For example, following the identification of more nursing hours being required, the role of the HCA was developed to perform immunisations and spirometry testing, which helped to alleviate some of the pressure on the nursing team.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team were forward thinking and were in the process of extending and refurbishing their site. This was initiated in response to the fact that the practice were using their existing resources to capacity and needed to develop, particularly as new housing developments were planned for the local area. The expansion would enhance facilities for patients and provide scope to potentially develop more services to be provided from the premises. For example, services such as physiotherapy which were previously offered on site had to re-locate due to increasing demand for the consultation rooms, but the extension could facilitate this and new services to provide clinics to improve local access for the practice population. This would also provide suitable premises as part of the CCG's 21st Century model to create more joined up working and fulfil the delivery of services closer to the patient's home.