Marylebone Health Centre

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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 8:30am on 9 December 2014. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to infection prevention and control.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to get an appointment when they needed one, but there was often a wait to see the GP of their choice. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Governance and performance management arrangements were proactively reviewed and reflected best practice. There was a clear leadership structure

Summary of findings

with a strong focus on staff education and training. All opportunities for learning from internal and external incidents were maximised and shared with staff and the patient partnership group (PPG).

- There were high levels of staff satisfaction and staff engagement, with staff at all levels actively encouraged to provide feedback and raise concerns. Staff felt supported and were offered training to upskill and develop within their roles. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Staff achievement was celebrated and shared with the practice and patients.

We saw several areas of outstanding practice:

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and the patient partnership group (PPG). The practice encouraged wider engagement from patients to ensure they were represented in PPG work. They proactively sought the opinion of people in different equality groups so that these patients could contribute to the development of surveys carried out by the PPG. A virtual patient representative group was also created to encourage representatives from different population groups to share their views on the service. Feedback was acted on in a timely manner and shared with patients and staff. The practice valued feedback from the PPG and engaged them in other areas of the service. For example, PPG representatives attended clinical commissioning group and locality meetings, and supported human resources as independent observers and decision makers during staff interviews.
- The practice worked with other organisations to improve care outcomes, and tackle health inequalities. The practice helped organise health promotion events for patients, staff and the local community. For example, there was a monthly 'Memory Café' offered in partnership with the parish church (where the practice was located), and a local healthcare provider. The aims of the meetings were to provide practical information and support for patients living with dementia, their families and carers. The practice also hosted quarterly 'Ask the Expert' events which were jointly organised with a local healthcare provider. These were educational events where healthcare specialists and professionals in the subject area were invited to give presentations to patients and staff.
- There was innovative leadership and a culture of continuous learning for all staff. There was a rolling programme of audits as demonstrated by the 17 clinical audits undertaken in the last year. Six of these were completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit and identify improved outcomes for patients. Audits were carried out based on the needs of the practice population and in response to feedback and performance.

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

Importantly the provider should:

- Complete a comprehensive risk assessment to manage infection prevention and control.
- Assess the competency of non-clinical staff who undertake chaperone duties and provide support where gaps are identified.
- Have a system in place to show that emergency equipment has been checked.

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 was rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe. Most risks to patients were assessed and well managed. The practice did however need to complete a comprehensive risk assessment to manage infection prevention and control within the practice.

Are services effective?

Good

The practice was rated as good for providing effective services. Staff referred to guidance from 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 capacity and promoting good health. Staff worked with multidisciplinary teams to manage patient care. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice was rated as good for providing caring services. Data from the National GP Patient Survey showed that patients rated the practice lower than others for some aspects of care. The practice were aware of this and had carried out consultation work with patients and the patient partnership group to improve these ratings. Practice surveys showed that patients were very satisfied with the care and treatment they received. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) and locality group to secure improvements to services where these were identified. Patients told us that they were able to get an appointment when they needed one, but there was often a wait to see the GP of their choice. The

Summary of findings

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

Are services well-led?

Outstanding 

The practice was rated as outstanding for being well-led. The practice had a clear vision with quality and outcomes for patients as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff, and staff education and training were seen as key factors in achieving the vision. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There were systems in place to monitor and improve quality and identify risk. There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice gathered feedback from patients, including people in different equality groups, and acted on it. The patient partnership group (PPG) was active and contributed to other areas of the service, including human resources.

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 was 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 and had a range of enhanced services, for example, in dementia and unplanned admissions. Patients aged 75 and over were sent details of their named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Clinical risk meetings, to discuss older patients with complex needs, were held with other healthcare providers including district nurses and a care navigator to coordinate patient care. The practice also offered vaccinations to older patients in line with current national guidelines.

People with long term conditions

Good

The practice was rated as good for the care of people with long-term conditions. GPs and nursing staff had lead roles in chronic disease management, and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients with long-term conditions had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice also conducted clinical audits on the management of patients with long-term conditions.

Families, children and young people

Good

The practice was rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children who were at risk, and these cases were reviewed with the health visitor every week. A good skill mix was noted amongst the GPs with some having additional diplomas in areas relevant to the needs of the local population, such as obstetrics and gynaecology, and children's health. Longer appointments were allocated for antenatal and postnatal checks, and childhood immunisations were carried out by the GPs and nurses. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had been involved in a health promotion event to raise awareness of minor illness and injuries in children, and local health services available.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice was 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. There were extended opening hours, text message reminders for appointments, telephone consultations, and online facilities to book appointments, request repeat prescriptions, and provide feedback. NHS health checks were offered to all patients between the ages of 40 and 74. This was an opportunity to discuss any concerns the patient had and identify early signs of medical conditions. Cervical smear tests were offered to patients in line with national guidelines. Travel vaccinations were administered at the practice, and health promotion material was available to patients in the practice and on the website. The practice also registered students from a local university and college. They attended university fresher's fairs to provide students with advice on how to register with the practice, and inform them of the services available such as counselling and sexual health advice.

People whose circumstances may make them vulnerable

Good

The practice was 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 housebound patients and those with a learning disability. It had carried out annual health checks for patients with learning disabilities and these patients were offered longer appointments. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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. There was a system in place for identifying carers, and these patients were offered health checks and immunisations. Referrals were also made so that carers could access further support, and a designated noticeboard in the practice provided carers with further information.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). Longer appointment slots were available for patients with mental health conditions. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental

Summary of findings

health, including those with dementia. The practice carried out clinical audits to improve dementia screening, and there were two GPs identified as clinical leads. The practice organised a monthly 'Memory Café' in partnership with the parish church (where the practice was located), and a local healthcare provider. The aims of the meetings were to provide practical information and support for patients living with dementia, their families and carers. The practice offered in-house counselling to patients through an enhanced service. There were also cognitive behavioural therapists and a primary care mental health worker who provided weekly clinics for patients.

Summary of findings

What people who use the service say

We spoke with six patients and six members of the patient partnership group (PPG) during our inspection. We reviewed seven CQC comment cards and a letter which had been completed by patients, data from the National GP Patient Survey 2014, and patient satisfaction surveys carried out by the practice and PPG.

Data from the 2014 National GP Patient Survey showed that 64% of respondents described their overall experience of the practice as 'fairly good' or 'very good', which was below the clinical commissioning group average of 83%. However, this did not reflect the results from the practice survey, or our interviews with patients and the PPG. Patients we spoke with said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment. They told us they were happy with the cleanliness of the environment and the facilities available. Patients we spoke with told us that they were able to get an appointment when they needed one, but there was often a wait to see the GP of their choice. Urgent appointments were available the same day. The comment cards reviewed were all positive and said the practice offered a professional service, and that staff were helpful and caring.

Areas for improvement

Action the service SHOULD take to improve

- Complete a comprehensive risk assessment to manage infection prevention and control.
- Assess the competency of non-clinical staff who undertake chaperone duties and provide support where gaps are identified.
- Have a system in place to show that emergency equipment has been checked.

Outstanding practice

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and the patient partnership group (PPG). The practice encouraged wider engagement from patients to ensure they were represented in PPG work. They proactively sought the opinion of people in different equality groups so that these patients could contribute to the development of surveys carried out by the PPG. A virtual patient representative group was also created to encourage representatives from different population groups to share their views on the service. Feedback was acted on in a timely manner and shared with patients and staff. The practice valued feedback from the PPG and engaged them in other areas of the service. For example, PPG representatives attended clinical commissioning group and locality meetings, and supported human resources as independent observers and decision makers during staff interviews.
- The practice worked with other organisations to improve care outcomes, and tackle health inequalities. The practice helped organise health promotion events for patients, staff and the local community. For example, there was a monthly 'Memory Café' offered in partnership with the parish church (where the practice was located), and a local healthcare provider. The aims of the meetings were to provide practical information and support for patients living with dementia, their families and carers. The practice also hosted quarterly 'Ask the Expert' events which were jointly organised with a local healthcare provider. These were educational events where healthcare specialists and professionals in the subject area were invited to give presentations to patients and staff.
- There was innovative leadership and a culture of continuous learning for all staff. There was a rolling programme of audits as demonstrated by the 17 clinical audits undertaken in the last year. Six of these

were completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit and identify improved outcomes for patients. Audits were carried out based on the needs of the practice population and in response to feedback and performance.

Marylebone Health Centre

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 CQC Inspection Manager and a GP specialist advisor. The GP specialist advisor was granted the same authority to enter the registered persons' premises as the CQC inspectors.

Background to Marylebone Health Centre

Marylebone Health Centre provides GP led primary care services to around 8,700 patients living in the surrounding areas of Marylebone, Regents Park, Fitzrovia, and Mayfair. The practice is located within the City of Westminster. The Indices of Multiple Deprivation (2010) shows that the City of Westminster was the 75th most deprived local authority (out of 326 local authorities, with the 1st being the most deprived). The practice holds a General Medical Services (GMS) contract with NHS England for delivering primary care services to the local community. The practice has a higher proportion of patients between the ages of 20-44, when compared with the England average. The proportion of patients under the age of 19 and over the age of 60 is lower than the England average.

The practice has two male GP partners and five salaried GPs (one male, four female) who collectively offer 37 sessions per week. The practice is a training practice and currently has a foundation year two doctor and a registrar who offer seven sessions each per week. There are three practice nurses and two health care assistants (one of whom is a locum). The number of sessions covered by the nurses equates to 2.23 WTE staff, and the health care assistants 1.75 WTE staff. Non-clinical staff includes a practice manager, reception manager, and a reception / administration team.

The practice is located on the lower ground level of a church. It is open every weekday from 08:30 to 18:30, except on Wednesday afternoons when it is closed to general callers and only patients with pre-booked appointments are seen. Extended hours are offered on Tuesday and Thursday evenings from 18:30 to 19:30, and Wednesday and Friday mornings from 07:00 to 08:00. Appointments must be booked in advanced over the telephone, online, or in person. The practice opted out of providing out-of-hours services to their patients. On Wednesday afternoons and outside of normal opening hours patients are directed to a GP out-of-hours service, or the NHS 111 service.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, and maternity and midwifery services.

The CQC intelligent monitoring placed the practice in band one. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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

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)

Before our inspection we reviewed a range of information we hold about the practice. As part of the inspection process we contacted key stakeholders which included NHS Central London (Westminster) Clinical Commissioning Group (CCG) and Healthwatch Westminster, and reviewed the information they shared with us.

We carried out an announced inspection on 9 December 2014. During our inspection we spoke with a range of staff including: the two GP partners; one salaried GP; foundation year doctor; two practice nurses; a health care assistant; practice manager; reception manager; and three administrative staff. We also spoke with a district nurse and a community care navigator who both worked closely with the practice. We observed how patients were being cared for and sought the views of patients. We spoke with six patients, and six members of the patient partnership group. We reviewed seven comment cards and a feedback letter where patients and members of the public shared their views and experiences of the service. We reviewed the practice's policies and procedures.

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. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Records were kept of significant events that had occurred and these were made available to us. Staff we spoke to were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events. We reviewed safety records, incident reports and minutes of meetings where these were discussed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff reported all significant events to the practice manager, and recorded the incident on a standard form which was stored on the practice's shared drive and accessible to all staff. Urgent incidents were discussed with the staff involved within 24 hours of occurring, and routinely with other staff during practice meetings.

We reviewed a summary of significant events, which showed there were seven incidents reported within the last 12 months. All incidents were logged with a summary of the event, learning achieved, actions agreed, and a review following the event. We saw evidence of action taken as a result, for example when there was a delay in reviewing a patient on multiple medications prescribed via dosette boxes. The practice had discussed the incident and took action by ensuring patients who were prescribed dosette boxes have a named GP who ensured the patient was reviewed regularly. A prescribing administrator, who was trained specifically in dosette box prescriptions, was also nominated to regularly review the system with the lead GP for prescribing. The practice had reviewed the actions taken and identified that there was a reduction in complaints related to delayed prescriptions.

Significant events and complaints were a standing item at the monthly practice meetings. There was evidence that the practice had learned from these and that the findings were shared with all staff. Patient safety alerts were received by the GP partners and practice manager, and disseminated by email to clinical staff. These were also discussed at weekly clinical meetings when changes to practice were required. For example, we saw an alert on cytology errors had been sent to the practice as it may have affected a patient before they were registered with the practice. Although the practice were not involved in the incident, they contacted the patient to inform them, and also discussed the practice's own cytology screening procedures.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. There was a system to highlight vulnerable patients on the practice's electronic records, for example patients who were housebound. The system also included information to make staff aware of any relevant issues when patients attended appointments; for example children with safeguarding concerns were flagged and families linked on the system.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had received the necessary training to enable them to fulfil this role, for example Level 3 child protection training. The practice provided annual in-house training on safeguarding vulnerable adults and child protection for all staff, and we saw evidence of the material covered in these sessions since 2012. The records confirmed that these sessions were conducted by the local authority safe guarding lead or the practice's safeguarding leads, and were attended by the GPs, practice nurses, and administrative staff. External professionals such as a health visitor, district nurse, and primary care navigator were also in attendance at the training sessions. Five out of seven GPs had received Level 3 child protection training. We saw evidence to confirm that the remaining two GPs and two practice nurses were booked to attend external training on safeguarding and child protection Level 3. Administration staff and the health care assistants had received Level 1 training. Staff we spoke with knew who the safeguarding leads were, how to recognise signs of abuse, and how to escalate concerns within the practice.

The practice had separate policies for child protection and safeguarding vulnerable adults. There were procedures for escalating concerns to the relevant protection agencies and their contact details were accessible to staff. The practice also had a shortened version of the policy on display in consulting rooms.

Good

Are services safe?

The practice did not have a written chaperone policy however there were posters in the reception area informing patients about the chaperone service. Staff had received 'consent and chaperone' training from an external organisation in 2013, and updates were provided during the internal safeguarding training in 2014. However, some non-clinical staff we spoke to were unclear about the role, for example the importance of being able to observe the examination.

Medicines management

Arrangements were in place to ensure medicines were stored securely and only accessible to authorised staff. There were procedures for ensuring that medicines were kept at the required temperatures, and the action to take in the event of a potential power failure. Fridge temperatures were checked daily by the practice nurses and we saw up-to-date logs to confirm this. We were told that medicines and emergency drugs were checked monthly by the nursing team and recorded on the computer system, however when we reviewed these records we saw that previous entries had not been saved and were overwritten by the current month's recording. This meant we could not review historical evidence of when medicines were checked. We notified the practice nurse and practice manager about this and were informed that this error would be rectified and records would be saved going forward. We checked a random selection of vaccinations and medicines and found they were stored securely and were within their expiry date.

There was a lead GP for prescribing who met regularly with the local medicines management team to ensure prescribing was safe and effective. We saw evidence of three ongoing audits initiated this year by the prescribing lead and clinical commissioning group pharmacist. There was also evidence that prescribing data was reviewed and shared with clinicians during practice meetings.

There was a system in place for the management of patients taking high risk medicines. The practice offered an in-house anticoagulation service so that patients taking warfarin could attend the practice for a blood test to measure the effectiveness of their medication. The prescribing lead conducted monthly checks of patients taking methotrexate to ensure these patients had received their blood tests and to review the results. The practice also kept a register of patients taking certain medicines, including methotrexate and lithium. We saw evidence that quarterly reviews were carried out to update the register and ensure these patients were monitored safely and attended for screening as clinically required.

Repeat prescriptions could be requested online, in person, or by fax. It was the practice's policy not to accept orders over the phone for safety reasons, except in emergencies. Repeat prescriptions were processed within 48 hours of a request being made. Certain administrative staff were trained to generate authorised repeat prescriptions and these were then reviewed and signed by a GP. The practice was preparing to adopt electronic prescribing, which would allow prescriptions to be sent electronically to a pharmacy of the patient's choice. Blank prescription forms were stored securely at all times. Vaccines were administered by the practice nurses using directions that had been produced in line with legal requirements and national guidance.

Cleanliness and infection control

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

The practice nurse and the practice manager were the leads for infection control and had undertaken training to enable them to provide advice on the practice infection control policy and carry out in-house training for staff. Staff received training specific to their role. For example, reception staff were provided with cleaning wipes and reminded that the reception desk should be cleaned in the afternoon period when there were no patients. We were told that hand hygiene techniques were reinforced with all staff, and we saw signs displayed by sinks to promote this. The practice had not carried out a recent infection prevention and control audit, and the last risk assessment was from 2010. The practice manager was aware of this and showed us a letter stating that the practice was awaiting an infection prevention and control visit from NHS England. Although an external cleaning company had carried out a recent health and safety risk assessment which covered some areas of infection control, it did not address all areas of infection prevention and control required for primary

care providers. The practice manager informed us that an updated comprehensive risk assessment for infection prevention and control would be carried out following our inspection.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves and aprons 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 needle stick injury policy which was on display in treatment rooms, and staff we spoke with knew the procedure to follow in the event of an injury. Hand soap, hand gel and hand towel dispensers were available in all consultation rooms.

The practice manager informed us that the building's management carried out maintenance of the premises, including the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However, the practice did not have the results of the investigations.

Equipment

Staff told us they had sufficient equipment to carry out their roles in assessing and treating patients. Equipment had been tested and calibrated in February and March 2014, and we saw records to confirm this for items such as blood pressure monitors, pulse oximeters and weighing scales. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was March 2014.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, and criminal records check via the Disclosure and Barring Service (DBS) for all clinical and non-clinical staff. We were told that the partners also obtained verbal references for GPs joining the practice. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place to ensure that enough staff were on duty, and this was monitored by the practice manager. There was also an arrangement in place for members of staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of medicines management, staffing, and dealing with emergencies and equipment.

An external cleaning company carried out health and safety checks of the environment, and we saw the latest risk assessment had been in December 2014. The building's management were responsible for maintenance of the premises and environment. For example, records showed that the alarm in the accessible patient toilet was checked last month. The practice manager told us that if there were any maintenance issues which required addressing, they would contact the building's management and document this in a maintenance log. We saw evidence that recent issues had been logged and resolved. The practice also had a health and safety policy which was made available to staff. Risks were also discussed at the monthly staff meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and told us that it was checked on a monthly basis. However, there were no records to confirm this.

Emergency medicines, including those for the treatment of anaphylaxis, were available in a secure area of the practice. We were told that the practice nurses carried out checks to ensure emergency medicines were within their expiry date and suitable for use. The 'drug check diary' confirmed that

Good

Are services safe?

the emergency medicines had been checked five times this year, including the current month. However, we were unable to view historical checks of the missing months due to the practice not saving this data. All the medicines we checked were in date and fit for use.

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of premises, power failure, incapacity of staff, and adverse weather. Named members of staff were identified as leads in different areas of the service (for example nursing, GPs, reception, IT). Further details were given to prioritise services which could be postponed, and others which must be continued. For example, prescriptions were prioritised as 'one day' for the length of time the service could be suspended before an alternative approved, whereas new patient health checks were prioritised as 'two weeks' following authorisation from the practice manager. 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. One of the partners told us that the business continuity plan was tested regularly to ensure staff were familiar with the protocols to follow in an emergency, and other staff confirmed this took place.

The building's management carried out annual fire risk assessments and we saw the most recent one had been carried out in September 2014. The fire alarms were also tested regularly, and we saw a log which confirmed these were tested last month. The practice manager was the nominated fire warden and we saw evidence that they had undergone training to fulfil this role. Staff we spoke with were aware of the fire evacuation procedures.

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 from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs told us they used the internet to access and keep up to date with NICE guidelines. We saw that clinical commissioning group (CCG) guidelines and locally agreed protocols had been summarised and were easily accessible via the practice's shared drive.

The staff we spoke with and the evidence we reviewed confirmed that guidelines were disseminated and the implications for patients were discussed and required actions agreed. These actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GPs told us they lead in specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD), and dementia, and the practice nurses supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice monitored their performance in many areas including A&E attendance. Data from the CCG confirmed that the practice's A&E attendance rate per 1,000 people during the last 12 months was 218.6 (CCG average 231.7). The practice carried out further internal reviews on A&E attendance of patients aged under 16, and ENT emergency referrals. The practice also engaged in internal and external peer review meetings to discuss A&E attendance. For example, they shared the A&E activity data with the patient partnership group (PPG) and worked on campaigns such as 'phone before you go' to reduce attendance rates.

The GPs attended CCG meetings, and monthly 'village' meetings with other practices in the locality. The 'village' meetings provided an opportunity for GPs to discuss complex cases where environmental and social issues were impacting on the patient's health, and these meetings were attended by a multidisciplinary team.

All GPs we spoke with used national standards for urgent referrals seen within two weeks, and we saw national templates were saved on the shared drive for easy access. Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing in-house and externally led clinical audit cycles. We were shown 17 clinical audits that had been undertaken in the last year. Six of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit on the number of patients diagnosed with dementia was carried out in October 2014. The first audit demonstrated that 32 patients had been diagnosed with dementia and were on the practice dementia register. This was lower than the public health outcome tool estimate of 58 patients. The GP partners agreed on an action plan and this was shared with all GPs and nurses during a practice meeting. The action plan included opportunistic screening during health checks and home visits, and not only when a patient presented with symptoms. The second audit cycle completed one month later showed that as a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the dementia register by two. The plan was to audit on a monthly basis to ensure outcomes for patients had improved. Another example included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We saw an audit regarding the prescribing of blood glucose meters for patients with type 2 diabetes. The aim was to review all these patients to ensure the testing frequency was appropriate to the medication

Good

Are services effective?

(for example, treatment is effective)

they were on, and to change the meter they were using in line with the CCG recommendations. The practice planned to re-audit in six months to determine if the changes implemented had been successful.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice reviewed this information on a monthly basis, and a comparison was made with last year's performance to identify further areas to work on. Last year the practice achieved 90% in the clinical domain for QOF, and met all the minimum standards in asthma, cancer, dementia, learning disability, palliative care. Overall the practice achieved 829/900 points for QOF, which was 8% above the CCG average and 1% below the England average. The staff we spoke with discussed how, as a team, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff, with the exception of a new staff member on induction, were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with some having additional diplomas in areas relevant to the needs of the local population, such as children's health, obstetrics and gynaecology, and geriatric medicine.

All GPs were up to date with their yearly 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 practice and remain on the performers list with NHS England).

All staff (excluding GPs) undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example external safeguarding training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointment times and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, cervical cytology. One of the practice nurses had an extended role as the diabetic lead nurse, and we saw evidence that they had appropriate training to fulfil this role.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically. The GP who saw these documents and results was responsible for the action required, and the duty GP was responsible for urgent enquiries or actions. For example, a change in prescription following out-of-hours care. All staff we spoke with understood their roles and felt the system in place worked well.

The practice worked with other healthcare providers to coordinate patient care. 'Village meetings' with a multidisciplinary team were held monthly to discuss patients with complex needs, for example those with

palliative care needs, multiple long-term conditions, mental health needs, housebound patients, and those recently discharged from hospital. These meetings were attended by GPs, district nurses, social workers, a care coordinator, counsellors, pharmacists, and occasionally a psychiatrist. There were also bimonthly meetings with the palliative care team. The district nurses and care coordinator shared the premises with the practice, and clinical staff remarked on the usefulness of having an 'open door policy' to share information with these professionals. There were also weekly meetings to discuss the needs of patients under the age of five, and to review the safeguarding and vulnerable family register. These meetings were attended by the health visitor, a GP partner and practice nurse. Updates were then shared with clinical staff during the weekly clinical meeting.

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. There was also a system for new patients registering with the practice to have their electronic notes linked from their previous GP surgery to the practice. Electronic systems were also in place for making referrals for specialist care and treatment in hospitals and community-based clinics via the Patient Referral Service (PRS). Performance data showed that since April 2014, 100% of referrals sent to the PRS were accepted, and the practice had a high level of appropriate referrals (98%).

The practice had also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was information in the practice and on the website informing patients of this. The practice told us that approx. 14% of patients had currently not consented to having their records shared.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. All staff were trained on the system, and newer staff told us that they received support from their managers when needed.

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. 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. Clinical staff we spoke with also 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

The practice met monthly with the CCG, locality group, and as a team to discuss the needs of the practice population. This information was used to help focus health promotion activity. It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Young people aged 15-24 were offered chlamydia screening during the health check. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 86 patients in this age group took up the offer of the health check (out of 139 patients who were offered the health check). Clinical staff used their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers, or signposting patients to health trainers who helped them develop healthier behaviour and lifestyles. There was a variety of health promotion information for patients to access in the practice and on the website.

The practice identified patients who needed additional support, and offered them additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Five out of the six patients had received a check-up in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients receiving end of life care, patients aged over 75, and those who were housebound. These groups were offered further support in line with their

Good

Are services effective?

(for example, treatment is effective)

needs. The practice kept a register of patients with mental health conditions. Data showed that 30/49 of these patients had a care plan in place. Patients with long-term conditions had personalised care plans and GPs we spoke with described the importance of a holistic approach to care and treatment. The nurses also monitored patients with long-term conditions, such as diabetes, asthma, chronic obstructive pulmonary disorder, hypertension, and coronary heart disease. Patients were encouraged to self-manage their condition, and we saw from the practice website that patients could update their clinical records by sending information such as blood pressure readings, weight, and alcohol intake to the practice.

The practice hosted quarterly 'Ask the Expert' events which were jointly organised with a local healthcare provider. These were educational events where healthcare specialists and professionals in the subject area were invited to give presentations to patients and staff. Topics of discussion this year included managing medicines, natural remedies, dementia, and carers.

The practice's performance for cervical smear uptake was 80%, which was 3% above the CCG area average. The practice also offered a full range of immunisations for children, travel vaccinations and flu vaccinations in line with current national guidance. The practice had currently provided flu vaccinations to 71% (626) of patients over the age of 65. This was the same as last year's (2013/14) overall uptake for this population group. The practice had also provided flu vaccinations to 37% (168) of patients aged six months to 65 years in the defined influenza clinical risk groups, which was below their previous year's overall uptake of 55%. As the practice were still offering the flu vaccination they were confident they would meet the previous years uptake. There was a system for monitoring patients who did not attend for screening or vaccinations, and this consisted of telephone calls, and letters sent from the practice and practice manager.

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 2014 National GP Patient Survey (103 responses received), and patient satisfaction surveys the practice and patient partnership group (PPG) had carried out in February 2014 (208 responses received). Data from the National GP Patient Survey showed that 64% of respondents described their overall experience of the practice as 'fairly good' or 'very good'. This was below the clinical commissioning group (CCG) average of 83%. The result from the PPG survey was 96%.

Data from the 2014 National GP Patient Survey showed that the practice was below the CCG average for patient satisfaction scores on consultations with the GPs and nurses, however this data did not reflect the results received in the practice survey. For example, the National GP Patient Survey showed that 70% of respondents said the GP was good at listening to them (CCG average 83%, PPG survey 99%), and 67% said the GP gave them enough time (CCG average 79%, PPG survey 98%). Satisfaction scores for consultations with the nurses showed that 59% of respondents said the nurse was good at listening to them (CCG average 72%, PPG survey 97%), and 59% said the nurse gave them enough time (CCG average 73%, PPG survey 98%). The practice was aware of the National GP Patient Survey results and was actively seeking to improve patient satisfaction by carrying out further in-house surveys specific to staff groups (i.e. care provided by nurses and health care assistants), and consulting with the PPG.

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and a letter, and all were positive about the service experienced. Patients said they felt the practice offered an excellent and professional service, and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All these patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical and non-clinical staff.

The practice were aware of patients whose circumstances may make them vulnerable to ensure these patients could access the service without fear or prejudice. Some clinical and non-clinical staff had received external training in learning disabilities to help them treat these patients in a sensitive manner. The practice had also identified a clinical lead for learning disabilities.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains or screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. An administration office was located away from the reception desk which helped keep patient information private. Staff told us that a privacy room next to reception could be utilised to prevent patients overhearing potentially private conversations between patients and receptionists. There was also a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The 2014 National GP Patient Survey information we reviewed showed patients responded less positively to questions about their involvement in planning and making decisions about their care when compared to other practices in the local area. However, these results did not reflect the data from the PPG survey where patients said they were sufficiently involved in making decisions about their care. For example, data from the 2014 National GP Patient Survey showed 61% of practice respondents said the GP involved them in care decisions (CCG average 71%, PPG survey 98%), and 70% felt the GP was good at explaining treatment and results (CCG average 78%, PPG survey 99%).

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

Good

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Staff told us that translation services were available for patients who did not have English as a first language, although we did not see notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection highlighted that staff responded compassionately when they needed help, and they were signposted to support services to help them manage their treatment and care when it had been needed. Comment cards we received also showed that patients were positive about the emotional support provided by the practice.

The practice was involved in a local initiative to identify and support carers and their families. A carer's lead had been identified and was responsible for coordinating formal carer awareness training for staff and updating the team on the practice's progress of identifying new carers. Since December 2013 the practice had increased the number of patients on the carers register from 25 to 37. Referrals were also made to external organisations and charities so that carers could access further support and information which may be relevant to them, for example financial support. A designated noticeboard in reception provided information for adult and young carers to ensure they understood the various avenues of support available to them. We also saw a comprehensive carer's pack including information and referral forms was available at reception. Staff were aware of patients' needs and told us that carers were offered health checks and immunisations. We saw that out of 20 carers who had been identified to receive the flu vaccination, five had received one.

The practice offered in-house counselling to patients through an enhanced service. Referral through a GP was required, and the service provided further support to patients who may need it, including those facing a bereavement or end of life care. We saw feedback from a recent CCG audit to confirm that the practice were performing over their target for the number of patients being treated per quarter. Referrals were also made to the Improving Access to Psychological Therapies (IAPT) service, and cognitive behavioural therapists and a primary care mental health worker provided weekly clinics for patients referred.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Patients could access a male or female GP. All patients with long-term conditions and those over the age of 75 years had a named GP who had overall responsibility for their care and support. The practice had written to all patients in these groups to inform them of their named GP. The practice offered longer appointments for patients who might require them, including patients with learning disabilities, mental health conditions, and multiple long-term conditions. Antenatal and postnatal appointments were also allocated additional time. Home visits and telephone consultations were available to patients who required them, including housebound patients and older patients.

The practice funded a complementary therapy service for patients. Suitability for these therapies was assessed by the appropriate therapist following a GP referral. The practice also carried out satisfaction surveys on these services. We reviewed the results of a survey on one of the therapies which showed that 4/5 patients were satisfied with the service, and all five patients said their conditions were helped by the treatment.

A monthly 'Memory Café' was offered in partnership with the parish church the practice was located in, and a local healthcare provider. The aims of the meetings were to provide practical information and support for patients living with dementia, their families and carers.

In April 2014 the practice hosted a puppet show in partnership with a local hospital. The aim of the event was to provide advice on managing minor illness and injuries in children, raise awareness about local health services and reduce A&E attendances. Families in the local area, whether they were registered with the practice or not, were invited to the event which was attended by child health specialists including paediatricians, nurses, play specialists, GPs, health visitors and pharmacists.

The practice engaged regularly with the clinical commissioning group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, an audit on how to improve the quality of A&E discharge summaries from a hospital trust was carried out by local GP practices and as a result an action plan had been provided by the hospital. We also noted that the practice engaged in peer review during these meetings.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient partnership group (PPG). For example, patients reported that last years (2012/13) practice survey was too long. The practice consulted with patients, the PPG, and patient reference group (patients who had consented to sharing their views with the practice over email), to identify what questions they wanted to see included in the survey. As a result a new survey with patient input had been created. Other improvements included the distribution of a quarterly PPG newsletter which provided practice updates, health promotion advice, and information on health care events for patients. The practice also continued to promote the online booking system to improve telephone access to the practice. Minutes from a PPG meeting confirmed that that the practice and PPG had managed to action all points from the 2013/14 action plan.

Tackling inequity and promoting equality

The practice provided equality and diversity training for staff at the annual away day. There was evidence that the practice understood the needs of different groups of people to deliver care in a way that met these needs and promoted equality. For example, carers were offered health checks and there was a designated noticeboard which provided information specifically for carers. The practice also looked after students from a local university and college. The practice attended university fresher's fairs to provide students with advice on how to register with the practice, and inform them of the services available such as counselling and sexual health advice. Although the practice were located on the lower ground floor of a church, they were open about being a non-denominational organisation who welcomed individuals from all

Good

Are services responsive to people's needs?

(for example, to feedback?)

backgrounds and faiths, both as patients and as staff. The practice had access to an interpreting service, and some members of staff spoke languages other than English. Patients commented that staff were receptive and attended to their needs.

The premises and services had been adapted to meet the needs of patients with disabilities. There was an external ramp and an internal lift to assist patients with accessing the practice. Accessible toilet facilities and baby changing facilities were also available. A hearing loop was in place to assist patients who had a hearing impairment. There was an automated check-in screen to allow patients to check themselves in for an appointment, or patients could also approach the reception desk.

Access to the service

The practice was open every weekday 08:30 to 18:30, except on Wednesday afternoons when it was closed to general callers and only patients with pre-booked appointments could attend. Extended hours were offered Wednesday and Friday mornings from 07:00-08:00, and Tuesday and Thursday evenings from 18:30-19:30. These appointments were useful for patients who could not access the practice during working hours.

Patients could book appointments online, over the phone, or in person. A number of emergency appointments were available each day, and patients were required to telephone the practice as early as possible to book these. Patients we spoke with confirmed they had previously been given emergency appointments on the same day of contacting the practice. Information about appointments was available to patients in the practice and on the website. Text message reminders for appointments and practice updates were utilised.

Routine appointments with the GPs were 10 minutes, and longer appointments were available for patients who needed them. The clinical sessions offered by individual GPs was advertised in the practice leaflet and on the website so that patients were made aware of the times they could see their preferred GP, and if this was not possible the other GPs on duty. Patients were generally satisfied with the appointments system. They told us that they were able to get an appointment when they needed one, but there was often a wait of two-three weeks to see the GP of their choice.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

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

We saw that information on the complaints system was made available to patients in the practice leaflet and on the website. Some patients we spoke with said they were aware of the process to follow if they wished to make a complaint. Other patients told us they would be comfortable making a complaint if required, and would initially approach staff with their concerns. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice kept a record of all concerns and complaints received verbally and in writing. We saw that 38 complaints had been received in the last 12 months and these had been investigated and responded to in a timely way. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review which showed the number of complaints relating to identified themes. For example, twelve complaints referred to appointments, four related to referrals, and eight referred to prescriptions. Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. There was also evidence of shared learning from complaints with the patient partnership group. All the staff we spoke with were aware of the system in place to deal with complaints, and said feedback was welcomed by the practice and seen as a way to improve the service. Staff told us they would try to diffuse any complaints, and if that did not resolve the issue, direct patients to the practice manager. The practice manager also held regular sessions where patients could talk to her about concerns or feedback they had, and this information was on the practice newsletter.

Are services well-led?

Outstanding ☆

(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 improve healthcare through innovation, research and education. They were committed to working in partnership with patients in the management of their healthcare, and there were numerous examples of how this was being achieved. For example, the monthly and quarterly health promotion events organised by the practice.

Staff we spoke with were aware of the practice's vision and knew what their responsibilities were in relation to these. We saw that the regular staff meetings and the practice away day helped to ensure that the vision and values were being upheld within the practice. There was also written information in practice leaflets and brochures so that patients were aware.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive. All the policies we looked at had been reviewed and were up to date. Monthly governance meetings were held between the partners. We saw evidence to confirm that the practice discussed performance, quality and risks during the weekly clinical meetings, and monthly practice meetings.

There was a clear leadership structure with the two GP partners and practice manager as senior management, and a range of clinical leads and named staff undertaking roles in other areas. For example, there were leads for safeguarding vulnerable adults, safeguarding children, and infection control. We spoke with 12 members of clinical and non-clinical staff and they were all clear about their own roles and responsibilities. They told us they felt supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. Information was reviewed on a monthly basis and compared with last year's performance to identify further areas for improvement. Clinical and non-clinical staff members were allocated a particular QOF domain to lead or support on. For example, we saw that one of the GP partners was the lead for coronary heart disease (CHD) and depression, the nurses led on hypertension and were supported by a GP, and the practice manager led on smoking and was supported by the administration team. The practice's QOF performance registers showed that the practice had maintained or improved their performance in all clinical domain areas when compared to the same period from last year. For example, in November 2013 the practice had achieved 7 points (out of 35) in the clinical domain area of chronic obstructive pulmonary disease (COPD), whereas in November 2014 they had achieved 21 points. This meant that health outcomes for patients with long-term conditions including COPD, CHD, and diabetes had improved. We saw minutes to confirm that changes to QOF and enhanced services were shared with staff.

The practice carried out a rolling programme of clinical audits which were used to monitor quality and systems to identify where action should be taken. Audits were conducted based on the needs of the practice population, and in response to feedback and performance. For example, an audit of inadequate smears and smear takers was undertaken to ensure that adequate samples were taken during cervical screening. If more than 2% of samples were returned as inadequate then the practice had procedures to follow, such as speaking with staff and supporting them with training. The practice re-audited this on a yearly basis. The practice was also involved in a peer review system with other practices in their locality to look at areas such as referral rates and A&E attendance.

Leadership, openness and transparency

We saw from minutes that whole practice meetings were held monthly, and clinical and administration meetings were held weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff that were unable to attend meetings were provided with minutes so that they were kept up to date with any changes that may have been implemented.

The practice carried out an annual centre review which in 2013 was attended by all practice staff, complementary therapists, counsellors, district nurses, and members of the patient partnership group (PPG). Each team (i.e. GPs, counsellors, therapists, PPG), were able to present their achievements over the past year, and describe their team objectives for the following year. The practice shared information on the surveys undertaken, complaints

Are services well-led?

Outstanding ☆

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

received, and commissioning updates. There was also a prize giving which recognised staff achievements. We saw the 2014 review had been planned to take place the day after our inspection.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example the recruitment and induction policies) which were in place to support staff. Staff could also access a 'concern in practice' policy which detailed internal and external procedures to follow if they had any concerns. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through multiple surveys on various aspects of the service, the patient partnership group (PPG), the patient representative group (PRG), and complaints received. The practice had a PPG who met with the practice every six weeks. The PPG members we spoke with told us that the GPs and practice manager were very good at updating them on practice issues. We saw from minutes that the meetings were well structured and covered a range of topics, including a review of the PPG action plan, practice surveys, complaints, and an open discussion for any further questions. The practice and the PPG told us they found it difficult to encourage representatives from various population groups, such as young families and students, to join the group. To assist with this challenge a PRG was created whereby patients corresponded with the practice and the PPG over email to share their views, complete surveys, and receive the newsletter.

The PPG carried out regular surveys. The practice wanted to ensure that patients representing all population groups had an opportunity to contribute to the development of surveys carried out by the PPG. The practice invited housebound patients and their carers to take part in practice surveys through their district nurse, and placed posters in local halls of residence to ensure the student population had the opportunity to take part. Parents attending child health clinics were asked by the health visitor about their views, and information was sent to patients on the risk registers. Information sheets in English, Spanish and French were available in the practice and staff who spoke languages other than English were available to translate if required. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

There was evidence that the practice involved the PPG in other areas of the service and valued their feedback. For example, we saw evidence that PPG representatives had attended locality and CCG meetings with practice staff, and were invited to support human resources as an independent observer and decision maker during staff interviews.

The practice gathered feedback from staff through meetings, appraisals, away days and an annual centre review. 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 in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

There was a strong focus on learning and training for all staff. We saw that clinical and non-clinical staff attended 'inter-educational' meetings where the practice invited guest speakers and trainers to present. An annual away day for all practice staff also incorporated learning and training sessions. The practice was a GP training practice and there was a structured induction programme for trainees that involved tutorials, shadowing staff and clinical supervision.

Staff told us that the practice supported them to maintain their professional development through training and mentoring. We looked at staff files and saw regular appraisals, which included a personal development plan, took place annually. Staff also told us that they could request further training to develop their roles. There was evidence that the practice had supported a receptionist to undertake training as a health care assistant. The practice also offered an apprenticeship programme in partnership with a local college. We saw that apprentices had a structured programme to receive training and development in various administrative roles. The practice manager told us that some apprentices were offered employment with the practice and had progressed within their roles. For example, an apprentice who had been employed as a receptionist had been promoted to reception supervisor.

Are services well-led?

Outstanding ☆

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

The practice had completed reviews of significant events, other incidents, and complaints, and these had been shared with staff during practice meetings to ensure the practice improved outcomes for patients.