Dr Joseph Fowler

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr. Joseph Fowler practice on 15 May 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Patients said that they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Information about services and how to complain was available and easy to understand.
- Although some clinical audits had been carried out, we saw little documented evidence to suggest these audits were driving improvement in performance to improve patient outcomes.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- There was a clear leadership structure and staff felt supported by management.
- The practice sought feedback from staff and patients, which it acted on.
- Patients had access to a psychologist for counselling and support each Thursday following a GP referral.

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

The provider should:

- Ensure the methods used for review and dissemination of learning from significant events and near misses are robust and maintain consistency in recording the analysis and outcome of significant events.

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- Ensure all staff are aware of and can identify with the practice vision and values.
- Formalise and strengthen the informal governance and leadership arrangements in place.
- Consider improving entry access for disabled patients.
- Consider an automated external defibrillator (used to attempt to restart a person's heart in an emergency for use in the event of an emergency).
- Ensure medicines for low blood sugar and seizure are available in the event of an emergency or complete a risk assessment in respect of why they are not required.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses and we saw these were acted on and that lessons were learned by that particular staff group. However, systems such as whole staff meetings to share this learning were not in place to encourage discussion and review actions from past significant events or incidents to support improvement. Staff were aware of the signs of abuse in older patients, vulnerable adults and children and were clear about their responsibilities. Staff succession planning needed to be robust in that all staff with defined roles could complete their roles and responsibilities regardless of the days they worked. We found there were no medicines for the treatment of low blood sugar or seizure available in the event of an emergency, or a completed risk assessment as to why they were not required. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency for use in the event of an emergency.

Are services effective?

Good

The practice is 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. Health promotion and prevention was routinely and opportunistically offered to reduce risks to patients' health. A practice newsletter was completed every six months. Practice staff put forward health topic ideas for the forthcoming newsletter for example, hay fever advice, patient reminders for annual health checks such as diabetes and advising patients as to new services such as the on-line prescription service go live date of June 2015. Staff had received training appropriate to their roles, and a system to record training was in place. Staff worked with multidisciplinary teams to support children and adults with complex needs and the community midwife visited the practice on a Monday and a psychologist on Thursdays.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Patients said they were treated with

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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 generally maintained confidentiality. Information and support was available for patients who also had caring responsibilities. Patients were not rushed and felt the clinical staff listened and understood their health needs and concerns.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice operated a GP telephone triage system for patients between 12pm and 12.30pm and patients spoke positively about the practice appointment systems. The practice had facilities which were equipped to treat patients and meet their needs. The practice provided co-ordinated and integrated care for the patients registered with them by engaging with multi-disciplinary teams, including the community matron and palliative care teams for example for end of life care. There were a range of clinics to provide help and support for patients with long-term conditions. There was an accessible complaints system and evidence which demonstrated that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity but did not hold specific governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice had a systematic approach to learning from incidents to drive improvement; these focused on the specific staff groups to whom the incident or event would normally affect rather than a whole team approach. However, there was no documented evidence to suggest that the completed clinical audits results were shared amongst the whole staff team as a learning and development opportunity to drive improvement in the service for patients.

The practice proactively sought feedback from staff and patients, which it acted on. The practice had started the process of setting up a patient participation group (PPG). Staff were aware of their roles and responsibilities, however improvement was needed to ensure all staff could complete all administrative tasks in the event of staff sickness. Staff had received regular performance reviews and

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attended staff meetings and events. The practice vision and values were not known amongst staff, although staff spoken with felt the practice value would be to put patients at the heart of everything they do.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice nurse had the lead role 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 had a named GP and a structured annual review to check that their health and medication needs were being met. The practice had62.9% of patients registered at the practice with a long-standing health condition and those with a long-term condition had received an annual review. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example regular communication with the Health Visitor. Children's immunisation rates were higher than the local Clinical Commissioning Group (CCG) average for all standard childhood immunisations with only one exception. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

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

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to ensure these were accessible, flexible and offered continuity of care. The practice was proactive and was in the process of setting up online prescription services and offered a full range of health promotion and screening that reflects 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 had systems in place to ensure that they could identify patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out health checks and offered longer appointments to people with a learning disability.

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). We saw that eight out of 12 patients with dementia had a care plan in place. The practice informed us this was an on-going process and these figures were from March 2015. The practice continued to make progress and review dementia and mental health patients to ensure they received an appropriate care plan and annual physical health check. The practice regularly worked with multi-disciplinary teams the majority of the time these were discussions rather than meetings in the case management of people experiencing poor mental health, including those with dementia. The practice acted on its feedback from a questionnaire and introduced educational literature and support for patients on subjects such as depression and anxiety in January 2015. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with four patients during the inspection and received 25 completed Care Quality Commission (CQC) comments cards in total. The majority of the patients we spoke with said they were happy with the service they received overall.

The results from the National GP patient survey published in 2015 for this practice found that 98% said the last GP they saw or spoke to was good at giving them enough time compared to the local Clinical Commission Group average of 82.3% and 96% said the last GP they saw or spoke to was good at listening to them compared to the local CCG average of 83.7%. Ninety five percent said the last GP they saw or spoke to was good at explaining tests and treatments which was higher than the CCG average of 78.4% and the national average; 93% said the last GP they saw or spoke to was good at involving them in decisions about their care and 91% said the last GP they saw or spoke to was good at treating them with care and concern both of which were higher than the local and national average. Ninety-nine percent of those surveyed said they had confidence and trust in the last GP they saw or spoke to. The survey found that 97% of respondents found it easy to get through to the practice by phone, which was higher than the local Clinical Commissioning Group (CCG) average of 72%.

The percentage of patients that would recommend their practice was 86% and 97% described their overall experience of this practice as good.

The practice at the time of the inspection did not have a Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The staff showed us the practice action plan which clearly demonstrated that they had discussed how best to set up their PPG and advertise for membership.

Patients were aware they could ask to speak to the reception staff in another room if they wanted to speak in confidence.

The practice had suggestion box. The GP informed us that they had very few suggestions posted. We found that there had been a suggestion raised by a patient in respect of colouring books for children in February and another patient suggestion for background music in the waiting room, these had yet to be acted upon.

Patients we spoke with told us they were aware of chaperones being available during examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GP, nurses and reception staff explained processes and procedures in great detail and were always available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service SHOULD take to improve

Ensure the methods used for review and dissemination of learning from significant events and near misses are robust and maintain consistency in recording the analysis and outcome of significant events.

Ensure all staff are aware of and can identify with the practice vision and values.

Continue the development of a patient participation group.

Formalise and strengthen the informal governance and leadership arrangements in place.

Consider improving entry access for disabled patients.

Consider an automated external defibrillator (used to attempt to restart a person's heart in an emergency for use in the event of an emergency.

Ensure medicines for low blood sugar and seizure are available in the event of an emergency or complete a risk assessment in respect of why they are not required.

Dr Joseph Fowler

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Dr Joseph Fowler

Dr. Joseph Fowler is located on Stafford Road, Wolverhampton and is part of the NHS Wolverhampton Clinical Commissioning Group. The total practice patient population is 2,063. The practice is in an area considered as a third more deprived when compared nationally. People living in more deprived areas tend to have greater need for health services. The practice has a higher proportion of patients aged 65 years and above (39.1%) than the expected national average (26.5%).

The staff team currently comprises a male GP providing five full day practice sessions. The practice team includes a practice nurse and three reception staff, employed either full or part time hours.

Dr. Joseph Fowler practice opening times are Monday to Friday (except Tuesdays), 9am to 12.30pm and 5pm to 6.30pm. Tuesday opening times are 9am to 12.30pm and 4pm to 6.30pm. A GP telephone advice service is available each day after the morning surgery normally between 12pm and 12.30pm.

The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed through the 111 telephone service where telephone calls are directed to Primecare, the out of hours service.

The practice provides a number of clinics such as long term condition management including asthma, diabetes and high blood pressure. It also offers child immunisations and travel health as well as minor surgery. Patients have access to a psychologist for counselling and support each Thursday following a GP referral.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities.

Why we carried out this inspection

We carried out 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.

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.

Detailed findings

How we carried out this inspection

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS Wolverhampton Clinical Commissioning Group, Healthwatch and NHS England Area Team. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We carried out an announced inspection on 15 May 2015. During our inspection we spoke with a range of staff including the GP, nurse and reception staff. We observed how patients were communicated with and how the practice supported patients with health promotion literature. We reviewed 25 CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available to patients at Dr. Joseph Fowlers' practice location prior to the 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia).

Good

Are services safe?

Our findings

Safe track record

The practice could evidence a safe track record over time. The practice had an effective system in place for reporting and recording significant events. Records were kept of significant events since 2009. We reviewed those that had occurred during the last 12 months which were made available to us. The practice manager was aware of their responsibilities to notify the Care Quality Commission about certain events. For example, if there was an occurrence that would seriously reduce the practice's ability to provide care.

The practice was able to use a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients. The practice used a software system to record incidents and staff demonstrated that they could all access this system. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The GP was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on.

Learning and improvement from safety incidents

We looked at how lessons learned from significant events were extracted and shared with staff. The GP informed us they decided which staff groups required the specific learning information from the significant events, incidents, accidents or complaints. They informed us this was to ensure that learning and development was focused and targeted to the right staff. An example included when the practice vaccine fridge temperature had failed to register within the expected range. The nurse practitioner reported this to the GP and Public Health England as well as contacting the specific vaccine manufacturers for advice regarding any measures to be taken regarding their use. This helped ensure the practice maintained a regime of continuous improvement. The whole practice team were aware of this event, action was taken immediately and learning shared with all staff. We saw that the whole practice meeting agenda regularly included reviews of incidents and complaints for example the January 2015 reported no complaints or incidents since the previous meeting in August 2014. A further incident had occurred whereby staff had been unable to access a specific file update to their computer systems. It was determined that the password had expired and needed to be unblocked and this was done. We saw that notes were made of the action taken and of the lessons learnt to prevent reoccurrence and that this was discussed with staff. We saw the practice had a system for managing safety alerts from external agencies. For example those from the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GP and nurse practitioner and action taken as required.

When significant events had been reviewed there was no documented evidence of an in-depth analysis of the events and although some, there was minimal documentation on what could be done to prevent them from occurring again. As an example we did not see evidence of any further specific training or audits undertaken as a result of significant events where there was potential or opportunity to do so. For example in one event the documented learning was limited to offering advice regarding a screening test to symptomatic patients. The practice had a clinical meeting in March 2015 between the GP and practice nurse to review any significant events over the previous 12 month period. There was no documentation as to whether there had been any themes or trends identified. There was no wider shared learning in respect of significant events for example with the CCG locality or peer group. The GP assured us they would consider how to address this.

Reliable safety systems and processes including safeguarding

The practice had policies in place in relation to safeguarding vulnerable adults and children. These were readily accessible to staff on the practice intranet and in paper copies. Staff we spoke with confirmed their awareness of them. We found that there was no paper copy of the adult safeguarding contact telephone numbers readily available to staff, however, the local authority and designated nurses for safeguarding children was available. When reported to staff this was promptly rectified. The GP was the adult and children's safeguarding lead for the practice.

Systems were in place to highlight vulnerable patients on the practice's electronic records. The practice could through their electronic records identify patients living in vulnerable circumstances including those with learning disabilities (LD). We saw that all clinical staff members had

completed safeguarding children and adults training to a level appropriate to their role and all staff were aware of how to recognise and safely report any safeguarding concerns.

The practice advised patients they could have a chaperone present during their consultation if they wished. We saw that staff could access the practice chaperone policy. When a chaperone was requested only staff who had received chaperone training and had a criminal record check completed by the Disclosure and Barring Service (DBS) took on the role.

Medicines management

Systems were in place for the management of medicines. Emergency medicines for cardiac arrest and anaphylaxis (shock) were available within the practice. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. There were no medicines for treating seizures or hypoglycaemia (low blood sugar) and there was no evidence of a completed risk assessment to identify why they were not stocked. The steroid medicines for use in an emergency and anti-emetics for nausea and vomiting were held in the GP's bag. We saw other medicines stored within the practice were in date and robust systems to check expiry dates were implemented. Oxygen was available and stored appropriately. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurse told us there were signed Patient Group Directions (PGD) in place to support them in the administration of vaccines which we saw was kept in the nurses' room. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. The PGDs were signed and checked by the practice nurse to ensure they were in date.

The practice was supported by the Clinical Commissioning Group (CCG) prescribing advisor. The prescribing advisor visited the practice on a weekly basis and advised of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. They regularly reviewed national prescribing data to show whether the practice was in line with the national levels of prescribing for antibiotics and medicines known to be addictive such as hypnotics. The prescribing advisor could initiate changes to patient medicines in response to updates if agreed by the GP. Staff told us patients were notified of the changes when they collected their prescriptions either from the practice or their local pharmacy. The practice checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP with an opportunistic approach. Written policies and procedures describing medicines management at the practice in the form of standard operating procedures were in place to help ensure consistency in practice.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. Vaccines were kept in a locked fridge. The fridge temperature was monitored and recorded. Staff were aware of the action to take if the temperature was not within the acceptable range. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. Patients could access travel vaccinations other than yellow fever at the practice and staff maintained appropriate records regarding patients in receipt of vaccines.

The practice had a protocol for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. The practice processed repeat prescriptions within 48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were stored securely in a locked cupboard. Security measures were in place for prescriptions access in line with suggested best practice within the NHS Protect Security of Prescription Forms guidance, August 2013.

The GP advised us that they took suitable precautions to prevent the loss or theft of their bag on home visits. If medicines were required they were carried in a locked carrying case and would not be left on view in a vehicle. Staff showed us that prescription serial numbers were recorded on receipt to the practice and were held securely.

Good

Are services safe?

The GP logged the serial numbers of the prescriptions and evidence was seen of these serial numbers. The GP assured us that the guidance produced by NHS Protect entitled, 'Security of prescription forms guidance,' was followed.

Cleanliness and infection control

Infection Prevention and Control (IPC) was monitored within the practice and the policy was available to all staff. This gave information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. There was an identified IPC lead, the practice nurse, who ensured all aspects of the policy were implemented fully. The lead had attended appropriate training to carry out her role. Infection control training was provided for all staff as part of their induction, and we saw evidence that training was updated regularly. The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated effectively.

We observed the premises to be visually clean and tidy and saw facilities such as hand gels, paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in the patient toilet. The foot pedal on the pedal bin in the staff toilet was broken and staff informed us this would be acted on and replaced. We saw there were hand washing facilities in the GP practice, nurse's treatment room and instructions about hand hygiene were displayed.

Protective equipment such as gloves and aprons were readily available. Screen curtains around examination couches were washable and a dated record kept of when this was last done. If curtains became soiled in the interim period they were changed immediately. Examination couches were washable and in good condition. Each clinical room had a sharps disposal bin. There was a record of when each bin started to be used. The practice employed cleaners and cleaning schedules were in place to make sure each area was thoroughly cleaned on a regular basis. The practice was cleaned in line with infection control guidelines and staff informed us that should the need arise they took on the responsibility to ensure their rooms were clean.

An audit was conducted in April 2015 by the Infection Control and Prevention team. The information following the audit was held on file at the practice with an action plan to address any areas requiring improvement. We saw that this had been communicated widely throughout the practice team.

There was a documented Legionella risk assessment in place. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We found that literature to inform staff about the Control of Substances Hazardous to Health (COSHH) was available for staff to read. Cleaning products for the contract cleaners were stored in lockable cabinets in line with COSHH.

Equipment

Evidence was kept at the practice to confirm annual safety checks, such as for fire extinguishers had been completed. Portable electrical appliances and equipment calibration had been carried out by the practice. The computers in the reception and clinical rooms had a panic button system where staff could call for assistance if required. Fire alarms and extinguishers were in place. Care and treatment was provided in an environment that was well maintained. Appropriate arrangements were in place with external contractors for maintenance of the equipment and building.

Staffing and recruitment

The practice had a stable staff team with the majority of staff employed for at least four years or longer. We looked at two staff recruitment records the majority of which were held in electronic password protected files. The sample included clinical and non-clinical staff. Records showed that there had been one recent recruit. The GP had recruited a staff member to assist with the practice's policy development and practice administration for eight hours each month. The GP was aware that records should include relevant checks such as references, as well as criminal record checks by the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks are checks to 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.

All staff had been subject to DBS checks. In one non-clinical staff file we saw that the DBS check held on file was from the staff member's other employer and the practice had yet to complete a risk assessment or repeat this staff member's DBS check. The GP had systems in place to check clinicians maintained medical indemnity insurance. In the records

seen there was evidence to show qualifications claimed had been verified, with copies held. We noted there was photographic proof of identity on staff electronic personnel files.

The GP told us that if a locum GP joined the practice on temporary basis they would make all the appropriate employment checks and to ensure their registration with the GMC was valid and check NHS England's performers list. There was no formalised system in place to verify the practice nurse registrations with the Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice. The practice nurse had copied the practice into their Nursing and Midwifery Council (NMC) registration updates which we saw were current. As a single handed GP practice the GP maintained their professional registration status with General Medical Council (GMC) and on the NHS performers list.

Reception and administration staff undertook similar roles and were multi skilled. We found however that in general, they worked set days and undertook specific roles on these days. Staff said should they be required to cover each other's sickness or absence they would refer to the GP for further support, guidance or information for the tasks they did not regularly undertake.

There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We saw there were days when one reception staff member was on duty in the afternoon and no nurse available. In the event that a patient required a chaperone this would leave the reception and waiting area without a staff member present for a short period of time. In the event of an emergency phone call or a patient waiting become unwell there was a low probability but a high risk potential of insufficient staff if a staff member was required as a chaperone. We saw the practice nurse worked part time and was available Tuesdays 9am-2pm and 4pm to 6.30pm and Wednesdays 9am to1pm each week. We reviewed the appointments and found that there were practice nurse appointments available at the next clinic which was within a reasonable period of time for patients. Staff informed us they had close working relationship with another local practice to provide additional support or cover should this be required. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medicines, equipment and the environment. We saw evidence these checks were carried out weekly, monthly and annually where applicable. We found that the practice in general ensured the appropriate checks and risk assessments had been carried out. Fire extinguishers and alarms were checked and maintained by an external company. The practice also had a health and safety policy and details of this were contained in the electronic staff handbook.

Events and incidents were discussed immediately following the episode and where appropriate at whole staff meetings. The practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety.

The practice had procedures in place to manage expected absences, such as annual leave, and unexpected absences, such as staff sickness. There was an accident book and staff knew where this was located. Staff reported that they always spoke to the GP if an accident occurred. They knew where to record the information and confirmed this was shared with other staff to reduce the risk of it happening again. Staff used an on-line reporting system to assist with monitoring any trends in incidents. Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff we spoke with were clear in describing the actions they would take in the event of a patient with a long-term condition requiring emergency intervention.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies, with the exception of medicines for low blood sugar and seizures. Records showed that all staff had received training in basic life support. Some emergency equipment was available including access to oxygen but there was no automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, all but one staff member was aware of the location of this equipment and records confirmed that it was checked regularly. Non clinical staff had access to documentation on emergency protocols

Good

Are services safe?

posted on the reception wall. When we spoke with staff however they could not recall having a written prompt The GP reassured us that this would be addressed and scenario discussions with staff would be held at practice meetings to further embed the training staff had received.

Emergency medicines were available in a lockable carry box within a secure central area of the practice and some medicines in the GPs bag. In general these were comprehensive and available to treat a wide range of medical emergencies. Examples were medicines for the treatment of cardiac arrest, anaphylaxis (allergic reaction), but not hypoglycaemia (low blood sugar level). The practice had a range of age appropriate emergency medicines available. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. When we spoke with staff we found they were aware of the business continuity plan. Each risk identified had mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan provided guidance on how to manage potential risks such as loss of information technology, premises, domestic and telephone services.

Fire training was completed as part of staff regular training updates and records were maintained. We found that staff could recall participating in a fire drill. Fire drills are essential in any workplace or public building for practicing what to do in the event of a fire and are a legal requirement under the Regulatory Reform (Fire Safety) Order 2005. Staff knew what they would do in the event of a fire; the fire assembly point and the name of the designated fire marshall. The fire exits were well signposted and free from hazards to prevent escape in an emergency, there was a designated fire marshall and the fire systems had been serviced.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidelines from the National Institute for Health and Care Excellence and from local commissioners. We were told from regular review of treatments and prescribing, the practice was able to review medications and stabilise patients using current guidance and recommendations. We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs and these were reviewed as appropriate.

Arrangements were in place to identify patients who required annual reviews of on-going care and treatment to ensure it continued to be safe and effective. There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. Referrals were managed primarily by using the 'choose and book' system, or when urgent, a fast track system. Staff followed up on each referral to ensure that it had been received, was progressed in a timely manner, and the result received back at the practice.

Requests for home visits were recorded by the reception staff, reported to the GP and patients received a GP phone call, assessed and where appropriate to do so a home visit was completed. Patients spoken with and several CQC comment cards received commented that they felt they were treated in an effective and timely manner.

The GP informed us the local Clinical Commissioning Group (CCG) pharmacy advisor visited each week and assisted in ensuring the practice's performance for example in antibiotic prescribing. Clinical Commissioning Groups (CCG) are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We saw that the local CCG benchmarked the practice against other practices in the locality. Discrimination was avoided when making care and treatment decisions. This information was provided to the practice as part of their Practice Support Visit carried out by the CCG. Areas identified as requiring improvement had been discussed and an action plan developed. Areas for improvement had been identified. One action was to invite patients with a severe mental illness for an annual health check and a review, a further action was to recall diabetic patients for Cholesterol monitoring which were actions in progress. Another action was to review patients with a diagnosis of dementia. Since the CCGs last support visit in April 2015 the CCG informed us the practice had increased their dementia reviews. The practice co-operated with NHSE in scrutinising their dementia register and had doubled the dementia register count.

The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular reviews. The practice nurse showed us that 131diabetic patients were eligible for an annual review. They informed us that all patients at the practice with diabetes had received an annual review. The practice used computerised tools to identify patients with complex needs for example end of life patients who had multidisciplinary care plans documented in their case notes.

We saw evidence that patients were referred promptly for specialist advice where required with the patients' involvement and understanding. New patient health checks were carried out by the practice nurse and regular health checks and screenings were on-going in line with national guidance. We saw that the number of new cancer cases treated (the percentage of which were two week wait referrals) was 52.9% compared with the CCG mean of 40.3% and England mean of 48.8%. Interviews with the GP and staff showed that the culture in the practice was that patients were cared for and treated based on need, and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

The practice showed us two clinical audits that had been undertaken in the previous year. In each of these completed audits the practice was able to demonstrate the changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved since the initial audit. An example included

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an audit for minor surgery consent between January and October 2014. This audit demonstrated improvement year on year in both written and verbal consent recording from the previous audit completed in 2013. The second was a cervical smear audit completed between June 2013 and May 2014 which found one inadequate smear in the 90 smears taken.

The practice reviewed the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and childhood immunisations. The practice was aware of any areas which required improvement within QOF (or other national) clinical targets and the GP informed us that they were making progress in this regard; for example in its recording of the percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who were treated with an appropriate bone-sparing agent.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. An example included the percentage of eligible female patients who attended cervical screening within a target period was 70.7%, this was in line with the CCG average of 70.8 % but both were below the England mean of 74.3%. The practice nurse informed us that as a practice they had and were taking measures to actively promote the importance of cervical screening.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions 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 GP confirmed that they reviewed the use of medicines for patients when alerts were received, and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. The practice maintained a palliative care register and had at least three monthly regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district, palliative care nurses such as the Macmillan hospice nurse practitioner, took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life.

Effective staffing

Practice staffing included medical, nursing, reception and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. The GP was up to date with the yearly continuing professional development requirements and revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the nurse informed us that they had taken on the role of lead nurse for infection control and as a nurse prescriber and had received training to support her in this role. We saw that there was little evidence that a formal induction programme had taken place for a new non-clinical staff member. The GP assured us that this would be addressed. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses.

The practice nurse performed defined duties and was able to demonstrate they were trained to fulfil these duties, for example, on administration of vaccines and cervical cytology. The practice nurse extended role training enabled

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(for example, treatment is effective)

her to provide support to patients with long-term conditions such as asthma, COPD and diabetes and as a prescriber. The practice nurse was aware of and preparing for the process of revalidation with their professional body.

Staff knew that where poor performance was identified, appropriate action would be taken to manage this. Staff were provided with access to the staff electronic handbook which included the practice's disciplinary process.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services both electronically and by post. Out-of-hours reports and pathology results were all seen and actioned by the GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances they could identify within the last year of any results or discharge summaries that were not followed up.

We were informed by the CCG that emergency hospital admission rates were below the CCG average at this practice. This was good when taken in context given that 39.1% of the registered patients were 65 years and older and had above CCG average numbers (4.9%) of over 85 year olds registered, and is in an area considered a third more deprived when compared nationally. Emergency hospital admission rates for the practice were relatively low at 12.9% compared to the national average of 13.6%.

The practice had access to multidisciplinary team meetings to discuss any patients with complex needs and had informal links with the community matron for ensuring integrated care. For example, (those with multiple long-term conditions, poor mental health, patients from vulnerable groups, those with end of life care needs or children recorded on the at risk register). These meetings were attended by appropriate health and social care professionals such as district nurses, palliative care nurses and community matrons and decisions about care planning were documented in a shared care record. The practice also worked closely with the local clinical commissioning group (CCG) prescribing advisor who supported the practice in the effective review and management of medicine prescribing. The GP and nurse felt this system worked well for then as a smaller practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff were unaware of any audits that had been carried out to assess the completeness of these records to identify gaps and put in place an action plan to address any shortcomings identified.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Staff spoken with had not received training on the Mental Capacity Act 2005. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. The staff spoken with told us if they had any concerns about a person's capacity to make decisions, they would ask the GP who would then carry out an assessment.

For some specific scenarios where capacity to make decisions was an issue for a patient, for example, with

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Are services effective?

(for example, treatment is effective)

making do not attempt resuscitation orders, the clinical staff were able to highlight how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of their care plans and where appropriate with the support of their family member, carer or advocate. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, patient's verbal or written consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the recorded consent process for minor surgery had being followed in 10 out of the 11 cases.

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

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP informed us that any health concerns detected were followed up in a timely way. This included information about medical conditions, family history, smoking and alcohol intake. New patients were offered a 'new patient' health check following review of their questionnaire. The GP used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic appropriate screening to patients. Patients could be referred to 'Healthy Lifestyles'. This service was for well patients with mental conditions such as diabetes or depression for example.

The practice's performance for the cervical screening programme was in line with the CCG average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. Staff noted some patients eligible for cervical screening were reluctant to attend despite regular reminders and phone calls. They mitigated the risk by having individual conversations with patients in order to reassure patients and dispel myths and to promote women's health screening. The practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for children's immunisations where comparative data was available. For example: Childhood immunisation rates for the vaccinations given to under twos ranged from 100% to 91.3% and five year olds from 100% to 90.9%. These were above CCG and National averages. Flu vaccination rates however for the over 65s were 57.42% which was below the national average of 73.24%. The GP was aware of these findings and planned to review these figures.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015 and the Friends and Family Test (FFT).

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was well above average for its satisfaction scores on consultations with doctors and nurses. For example:

• 96% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 83.7% and national average of 87.2%.

• 98% said the GP gave them enough time which was higher than both the CCG and national average.

• 99% said they had confidence and trust in the last GP they saw which was higher than both the CCG and national average.

• 97% said they had confidence and trust in the last nurse which was higher than both the CCG and national average.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 29 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive but this was not a common theme. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtain 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. One of the practice switchboard telephones was located away from the reception desk and the other was shielded by glass partitions which helped keep patient information private. The design of the practice allowed only one patient at a time to approach and speak at the reception desk. This assisted in maintaining private conversations between patients and reception staff. Additionally, 92.6% said they found the receptionists at the practice helpful which was higher than both the CCG and national average.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the GP or practice nurse. The GP told us they would investigate these and any learning identified would be shared with staff.

People whose circumstances may make them vulnerable were able to access the practice without fear of stigma or prejudice. Staff treated people from these groups in a sensitive manner and training in equality and diversity had been completed by all staff bar one.

Care planning and involvement in decisions about care and treatment

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

• 95% said the last GP they saw was good at explaining tests and treatments which was higher than both the CCG and national average.

• 93% said the last GP they saw was good at involving them in decisions about their care which was higher than both the CCG and national average.

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

Good

Are services caring?

supported by staff and had sufficient time during 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. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

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

• 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77.6% and national average of 82.7%.

• 94% said the last nurse they spoke to was good at treating them with care and concern which was higher than both the CCG and national average.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Patients were asked on registration if they had any caring responsibilities and the computer system alerted staff if a patient also had caring responsibilities. The practice nurse recognised that as a practice they needed to be more proactive about asking patients about caring responsibilities to ensure they identified changing circumstances.

Staff told us that if families had suffered bereavement, the practice would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged on an irregular basis with them to discuss local needs and service improvements that needed to be prioritised. The practice told us they had received CCG Practice Support Visits, and action plans were derived from the visits; they acted as a form of external peer review and they discussed service improvements to better meet the needs of its population. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the CCG. For example the CCG had identified three areas for improvement, one, for example, was in diabetes cholesterol monitoring. By April 2015 the CCG found these areas had been addressed.

The practice did not have a patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice was looking to set up a virtual PPG. The practice proposed to place posters informing patients of this in the waiting room and potentially add this information to the practice website.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, patients with a learning disability and refugees or migrants. Staff told us that these patients were supported to register as either permanent or temporary patients. The practice had accepted patients who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

The premises and services had not been designed to meet the needs of people with disabilities but adaptations had been made to the premises. The practice facilities were all on one level and there were accessible toilets and baby changing facilities. There was a large waiting area with space for wheelchairs and prams. There was a ramped access to the main entrance of the practice. However, the practice did not have automated doors to assist wheelchair users.

Staff told us that they did not have any patients currently who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There was a male GP but no female GP at the practice and this was made apparent in the patient literature.

The practice provided equality and diversity training through their on line learning system. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed.

Access to the service

The practice opening times were Monday to Friday 9am to 12.30pm and 5pm to 6.30pm with the exception of Tuesday. Tuesday opening times were 9am to 12.30pm and 4pm to 6.30pm. A GP telephone advice service was available each day after the morning surgery, normally between 12pm and 12.30pm. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The practice answerphone message gave callers the telephone number they should ring for the out-of-hours service and the practice brochure also gave patients information on the out-of-hours service provided.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice highly in these areas. For example:

• 84.2% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75.7%.

• 96.8% described their experience of making an appointment as good compared to the CCG average of 73% and national average of 73.8%.

• 83.9% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62.1% and national average of 65.2%.

• 97% said they could get through easily to the practice by phone which was higher than both the CCG and national average.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent**.** Routine appointments were available for booking up to two weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

Older patients, those with long-term conditions and the most vulnerable in the practice population had access to longer appointments when needed and home visits where assessed as appropriate. Appointments were available outside of school hours up to 6.30pm for children and young people. The practice clinical staff held telephone consultations where appropriate and the details recorded in the patients notes. Staff described that many of their registered population had been patients at the practice for a long time and as such were well known to staff. Using this local knowledge staff avoided booking appointments at busy times for those patients who may find it stressful.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system posters displayed, patient practice summary leaflet available and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last 12 months and found these were dealt with in a timely way and demonstrated openness and transparency in dealing with these complaints.

The practice reviewed complaints annually to detect themes or trends. We looked at the records and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. No complaints had involved the Ombudsman. Evidence of shared learning from complaints with staff included minutes of team meetings which showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. An example included an incident reported on the practice's electronic system regarding a prescribing error were recorded on the practice report and the actions and learning which took place to reduce the risk.

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

We saw that the practice aims and objectives contained within their statement of purpose were to provide primary care services in a safe way and to a high quality, and to abide by the principles of Good Medical Practice as published by the General Medical Council (GMC). Staff we spoke with were unaware of any documented practice vision or values. Staff they told us they considered the practice value would be to put patients at the heart of everything they did. The practice did not have a written strategy or business plan in place. A business plan would allow the practice to focus on future planning in taking the practice forward. The GP told us they would consider and review this.

We spoke with a number of patients, staff and other health professionals who all spoke very positively about how the practice worked to fulfil its aims and objectives

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The practice had systems in place to assess and monitor the quality of services. A new staff member had been recruited whose role included assisting the practice in its policy development and review process. We looked at seven of these policies and procedures and found staff had confirmed that they had read the policy. All seven policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. We found that some staff undertook specific administration tasks on specific days which in the event of staff sickness had the potential to unnecessarily add to the GPs workload. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice nurse took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing generally in line with national standards and the GP was aware of the QOF indicator descriptions requiring further attention or action. The practice minutes seen did not demonstrate that QOF data was regularly discussed at meetings or that action plans were produced to maintain or improve outcomes. However the clinical staff informed us they discussed the management of patient outcomes and regularly reviewed software systems available to them to monitor quality.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction such as the Friends and Family Test (FFT) and action would be taken, when appropriate, in response to feedback from patients or staff. The practice engaged with the Clinical Commissioning Group (CCG) quality practice visits and submitted governance and performance data. The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged on an irregular basis with them to discuss local needs and service improvements that needed to be prioritised. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example the content of practice business continuity plan.

The practice held on a three to four monthly basis an all practice staff meeting. There was no specific governance meeting held. We looked at minutes from the practice meetings and found that elements of performance, quality and risks were discussed, such as incidents and complaints, health and safety, infection prevention and staff training.

Are services well-led?

Good

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

The GP was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, management of sickness) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections for example on disciplinary procedures. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff electronically within the practice.

We found there were gaps and a lack of evidence of any wider sharing such as with significant event analysis (SEA) or locality peer support meeting attendances.

External peer review was provided by the local Clinical Commissioning Group (CCG) through the Practice Support Visit, which was carried out in August 2014 and April 2015. The reports from the visits identify any areas which required improvement and the practice developed an action plan to address them.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract the practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is an incentive scheme which rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing in line with the local CCG average. However, we saw that QOF data was not recorded as an agenda item regularly discussed at the clinical team meetings.

Leadership, openness and transparency

The practice staff told us the GP was very approachable and always took time to listen to all members of staff. Staff told us they were involved in discussions about how to run the practice and how to develop the practice: the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every three to four months. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported.

We looked at the agenda for the practice meetings. The meetings were used to discuss a range of topic, including feedback from the local Clinical Commissioning Group and infection control team.

The GP was responsible for human resource policies and procedures. We reviewed a number of policies, such as the locum induction policy and recruitment policy which were in place to support staff. The policies were all stored electronically and 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 gathered feedback from patients through the GP national patient survey, comments, complaints, and compliments. The practice did not have a Patient Participation Group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice was actively trying to introduce a PPG and had discussed the process of how best to recruit to its membership. The practice did participate in the NHS Friends and Family Test, and feedback rates were very good. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us when they asked for any practice specific training the GP had agreed and encouraged them. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that some training days included external trainers.

Are services well-led?

Good

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. An example of an incident included a staff member's password expiring, which had the potential to delay GP access to patient test results onto their electronic systems. Remedial action was taken immediately and a failsafe measure put in place to reduce the risk of reoccurrence.

The GP and nursing staff told us that significant events were shared with staff at practice team meetings. However the minutes of meetings we saw did not demonstrate the detail of the discussions or of any learning that had taken place. There was no evidence to suggest that the completed clinical audits results were shared amongst the whole staff team as a learning and development opportunity and to drive improvement in the service for patients.

The GP was responsible for staff inductions and ensuring staff competence in their role. We spoke with five staff members who told us there were clear lines of accountability and strong leadership within the practice. They told us they felt well supported and secure in their role.