Millwood Surgery

Quality Report

Mill Lane
Bradwell
Great Yarmouth
Norfolk
NR31 8HS
Tel: 01493 661549
Website: www.millwoodsurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Millwood Surgery on 9 July 2015. We found that the practice provided a safe, effective, caring, responsive and well led service. The overall rating for this practice is good.

We examined patient care across the following population groups: older people; those with long term medical conditions; families, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. These were all investigated and learning was identified and acted upon. These included incidents where things had gone well, so that positive practice was shared too.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information was provided to help patients understand the care and treatment options available to them.
- The practice was friendly, caring and responsive. It addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- High standards of patient care and service were promoted and owned by all practice staff with evidence of effective team working across all roles.
- The clinical and managerial leadership at the practice was forward thinking and supportive.

Summary of findings

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

- Improve the security of access to emergency medicines and the documentation of the amount of emergency medicine held in stock.
- Ensure the legionella management policy is completed.
- Ensure the practice is correctly registered with CQC to provide the regulated activity of surgical procedures.

We saw one area of outstanding practice:

- One of the GP partners completed the annual appraisal with each member of staff. There was a proactive culture of learning and support between all members of the practice. Staff spoke positively of the support they received and told us they felt valued by having a GP undertake their annual appraisal.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. When things went wrong these were investigated to help minimise reoccurrences. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed. Patients, including children, who were identified as being at risk, were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe and the practice had been able to recruit GPs to maintain the optimum patient/GP ratio. Premises were clean and risks of infection were assessed and managed. The practice had suitable equipment to diagnose and treat patients and medicines were stored and handled safely.

Are services effective?

Good

The practice is rated as good for effective. Data showed the majority of patient outcomes were average for the locality. National Institute for Health and Care Excellence (NICE) guidance and other best practice guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. We saw evidence of effective multidisciplinary working demonstrated by weekly meetings and regular palliative care meetings. There was an effective induction and competency programme for new staff to the practice. Staff had received training appropriate to their roles and further training needs had been identified and planned for. Staff had received annual appraisals and reported that these were supportive and positive.

Are services caring?

Good

The practice is rated as good for caring. National and local data showed patients rated the practice average or above average for several aspects of care. Patients we spoke with and received comments from told us they were treated with compassion, dignity and respect. They were listened to by all staff and involved in care and treatment decisions. Feedback from patients and from their

Summary of findings

representatives was extremely complimentary. Accessible information was provided to help patients understand the care available to them. We also observed that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed and addressed the needs of their local population. All of the patients we spoke with and the majority of those we received comments from were satisfied with the appointments system. The practice offered urgent appointments, available the same day, pre-bookable appointments, home visits and advice was given by telephone. The practice was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. There were aims and objectives in place and staff were aware of their responsibilities in relation to these. The practice was a training practice for qualified doctors who were training to be GPs. There was effective leadership and staff we spoke with felt supported in their work. The practice had a number of policies and procedures to govern its activity and those we looked at had been dated and reviewed. Regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff attended staff meetings and peer support meetings and received annual appraisals.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed the practice had average outcomes for conditions commonly found amongst older patients. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. Patients who had unplanned admissions to hospital were reviewed and appropriate support provided. The most vulnerable patients had a care plan in place and were reviewed on a quarterly basis. The practice offered proactive, personalised care to meet the needs of the older patients in its population. The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those with enhanced needs. Flu vaccinations were undertaken at the patient's home for housebound patients.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. The practice had clinical leads for long term conditions. An advanced nurse practitioner led on chronic disease management, supported by practice nurses who led clinic appointments for a number of long term conditions, including asthma and diabetes. All patients with long term conditions had structured reviews, at least annually, to check their health and medication needs were being met. Care plans were agreed for patients with chronic obstructive pulmonary disease and rescue packs were issued, so patients had immediate access to emergency medicines, which reduced the need for a hospital admission. A diabetes specialist nurse held a monthly clinic at the practice for those patients with complex diabetes. For those patients with the most complex needs, the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. A weekly 'drop in' nurse led vaccination clinic was held.

Summary of findings

A midwife led clinic was available for patients on a weekly basis. A recall system was in place for the mother and baby six week check. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Early morning appointments were available Monday to Friday from 8 am and on a Monday evening until 8pm. Appointments could be booked in person, by telephone or online. Repeat prescriptions could also be requested online. A full range of health promotion and screening which reflected the needs for this age group was also available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and 46% had received an annual health check in the previous year. Nationally reported data showed the practice performed below the Clinical Commissioning Group (CCG) and England average for patients with a learning disability. However the practice had recognised this and there was a clinical lead with responsibility for learning disabilities. They were actively recalling patients with a learning disability to offer them a health check and there was a process for following up vulnerable patients who did not attend for their appointment. Longer appointments were given to patients who needed more time to communicate during a consultation, for example patients who needed an interpreter. There were arrangements for supporting patients whose first language was not English. The practice worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. Nurses visited the local traveller site to give flu vaccinations.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including patients with dementia). The practice held a register of patients with dementia. Nationally reported data showed the practice performed below the Clinical Commissioning Group (CCG) and England average for patients with dementia and for mental health. However the practice had recognised this and there was a clinical lead with responsibility for dementia. They were actively recalling patients to offer them a health check. There was a process for following up patients with poor mental health and those with dementia, who did not attend for their appointment. The practice had online dementia training available for staff. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. Patients were referred to other mental health services as appropriate.

Summary of findings

What people who use the service say

The practice had informed patients that we were visiting on the 9 July to undertake an inspection. Patients had been invited to attend the surgery on the day of the inspection to share their views or leave a comment on the cards provided by us.

We spoke with seven patients during our inspection. All of the patients told us that they were able to get an urgent appointment on the same day, although two reported that sometimes appointments ran behind time. They commented positively on having sufficient time with the GP and nurses and were listened to by them. Patients were very complimentary about the expertise of the clinical staff. All of the patients told us that staff at the practice were friendly and helpful which made them feel genuinely cared for. They also reported a good experience with getting repeat prescriptions.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 64 Care Quality Commission comment cards. All (100%) of the comments cards contained positive feedback about the practice. Patients reported that all the staff were friendly, helpful and caring. There were many positive comments about the quality of the clinical care provided and the professionalism of the staff. The majority of patients reported that they were able to get an appointment easily, although two patients were dissatisfied with the wait for a routine appointment. One patient reported that there could be a wait for the telephone to be answered when the surgery opened, but advised they were able to get an appointment.

We spoke with representatives from two care homes where patients were registered with the practice. They were complimentary about the service provided by the practice. A specific GP visited every week, or was available to visit if there was a patient need. This ensured continuity of care for the registered patients. They reported that patients were treated with dignity and respect. We were told that patient consent was obtained when this was needed and that they involved patients and when appropriate, staff and relatives appropriately in care and treatment decisions, especially if patients did not have mental capacity to consent. Patients with long term conditions were monitored and reviewed in their home by the named GPs regularly. They reported that referrals had been made in a timely way and were satisfied with obtaining repeat prescriptions. Representatives knew how to complain if they needed to. One representative told us that they had complained and the matter had been investigated and resolved to their satisfaction.

Areas for improvement

Action the service SHOULD take to improve

- Improve the security of access to emergency medicines and the documentation of the amount of emergency medicine held in stock.
- Ensure the legionella management policy is completed.
- Ensure the practice is correctly registered with CQC to provide the regulated activity of surgical procedures.

Outstanding practice

- One of the GP partners completed the annual appraisal with each member of staff. There was a proactive culture of learning and support between all members of the practice. Staff spoke positively of the support they received and told us they felt valued by having a GP undertake their annual appraisal.

Millwood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP Specialist Advisor. The team also included a practice management specialist advisor.

Background to Millwood Surgery

Millwood Surgery, in the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) area, provides a range of general medical services to approximately 10200 registered patients living in Gorleston, Bradwell and the surrounding villages.

According to Public Health England information, the patient population has a slightly lower than average number of patients aged 0-18, and slightly higher than average number aged 65 and over, 75 and over and aged over 85 compared with the practice average in England. Income deprivation affecting children and older people is slightly below average compared with the practice average across England. A slightly higher than average number of patients have a long standing health condition. A significantly higher percentage of patients have a caring responsibility compared to the practice average across England.

There are six GP partners, four male and two female who hold financial and managerial responsibility for the practice. There is one salaried GP with a new salaried GP joining in August 2015, one nurse practitioner, three practice nurses (one of which can prescribe), a health care assistant and a health care support worker. There are also receptionists, administration staff, a practice manager and an assistant practice manager. The practice is a teaching practice for medical students and qualified doctors who are training to be GPs.

The practice provides a range of clinics and services, which are detailed in this report, and operates between the hours of 8am and 6.30pm, Monday to Friday with additional hours until 8pm on a Monday. Outside of practice opening hours a service is provided by another health care provider IC24.

Why we carried out this inspection

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

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

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and other information that was

Detailed findings

available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the service. We talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch. The information they provided was used to inform the planning of the inspection.

We carried out an announced inspection visit on 9 July 2015. During our visit we spoke with a range of staff, including four GPs, four nurses, a health care assistant, a health care support worker, a GP registrar, the reception manager, four reception and administrative staff, the assistant practice manager and the practice manager. We spoke with seven patients who used the practice. We reviewed 64 comments cards where patients had shared their views and experiences of the practice. We spoke with representatives from two residential homes where patients were registered with the practice.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to 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 used a range of information to identify risks and improve patient safety. Incidents and national patient safety alerts as well as comments and complaints received from patients were reviewed appropriately and learning was shared across practice staff. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records and minutes of meetings where safety was discussed. There were records of significant events that had occurred during the last five years and we were able to review these. This showed the practice had managed these consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including receptionists and clinical staff were aware of the system for raising significant events and felt encouraged to do so. Significant events and complaints was a standing item on the weekly clinical meeting agenda and we saw evidence that significant events and complaints were discussed and actions from past significant events and complaints were reviewed.

We looked at the records of 29 significant events that had occurred since September 2014. We noted that significant events had been raised by both clinical and non-clinical staff. They included significant events which had gone well and had been raised and reviewed in order to share good practice. We looked at a number of significant event analyses. These had been completed in a comprehensive and timely manner and we saw evidence of action taken as a result. One significant event related to improving the process for receiving samples at the practice. A new procedure was written, agreed and implemented.

National patient safety alerts were disseminated by the practice manager to all clinicians. They were also raised at the weekly clinical meeting and if any follow up of action was needed this was decided at the meeting. Staff we spoke with confirmed this happened.

Reliable safety systems and processes including safeguarding

The practice had a range of documentation to advise staff of their role and responsibility in relation to safeguarding children and vulnerable adults. We asked members of medical, nursing and administrative staff about their safeguarding knowledge. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed a GP as the dedicated lead in safeguarding vulnerable adults and children. They had been trained to level three, as had the other GPs and nurses in the practice. All staff we spoke with were aware who the lead for safeguarding was and who to speak with in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a system to highlight vulnerable patients on the practice's electronic records. There was a process in place for following up patients who did not attend for their appointment. The practice had undertaken proactive work in identifying those patients who were due for a long term condition review and who might not attend, for example, due to being housebound. These patients were then actively followed up to ensure that they did receive a review.

There was a chaperone policy and patients we spoke with were aware they could request a chaperone. There were notices informing patients that this service was available. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We noted that only clinical staff acted as chaperones and they had had a Disclosure and Barring Service check to help ensure their suitability to work with vulnerable people. Disclosure and Barring Service (DBS) checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Good

Are services safe?

Medicines management

Refrigerator temperatures were taken daily and the minimum, maximum and actual temperatures were documented. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Guidance was available to staff which explained what to do in the event of refrigerator temperatures being outside of the accepted range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery. Medicines for use in an emergency in the practice were monitored for expiry and checked regularly for their availability. Medicines were not kept in GPs bags. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses used Patient Group Directions (PGDs). These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The nurses used these to administer vaccines and other medicines and we saw that the PGDs had been produced in line with legal requirements and national guidance. They were signed and up to date. We saw evidence that nurses had received appropriate training to administer the medicines referred to in the PGDs. A member of the nursing staff was qualified as an independent nurse prescriber. They received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Paper prescriptions, rather than electronic prescriptions were used for high risk medicines. Prescribing alerts were in place on patients' computerised records to alert the prescriber if high risk medicines were going to be over prescribed.

The process for safely storing and signing out prescription pads by and to authorised persons was not robust. We found that prescription pads were not stored securely and the records of these did not match what was in stock. Some blank prescription forms were not accounted for or recorded. We raised this with the practice manager who immediately ensured that the prescription pads and blank prescription forms were stored securely and records put in place to account for these. The morning after the inspection, we were sent a copy of the prescription security risk assessment and prescription security protocol, which had been developed by the relevant staff and clinicians at the practice. We were assured from what we observed in response to identifying this issue and from the written evidence submitted after the inspection that prescription pads and blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with and received comments from told us they found the practice clean and had no concerns about cleanliness or infection control. The practice used an external cleaning company. We saw there were cleaning schedules in place. Some cleaning responsibilities were undertaken by clinical staff, for example cleaning of medical equipment. There were internal cleaning schedules in place for this and evidence that these had been completed. One of the nurses had responsibility for undertaking ad hoc spot checks of the cleaning and records were kept which demonstrated that this happened.

The practice had a lead nurse for infection control, who worked closely with the clinical commissioning group infection control team. We saw evidence that the infection control lead had carried out an infection control audit in August 2014. Improvements had been identified for action and these had all been completed. A hand washing audit had been completed for all staff.

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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. All staff underwent screening for Hepatitis B immunity and records we checked confirmed this. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. Personal protective equipment including disposable gloves, aprons and examination couch coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Good

Are services safe?

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid soap, liquid gel and paper towel dispensers were available in treatment rooms.

A legionella risk assessment had been completed, however it was due for renew in January 2014 and had not been. The practice manager advised that they did checks of the boiler temperature, although these were not documented. The practice manager had started a legionella management policy and was aware of the work that needed to be completed. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment, for example an ear syringe and an electrocardiogram (ECG) machine. The next portable electrical equipment testing and calibration was due September 2015.

Staffing and recruitment

The practice had a recruitment policy and procedure that set out the standards it followed when recruiting clinical and non-clinical staff. 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 checks through the Disclosure and Barring Service (DBS). We saw that checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty. Staff told us there were enough staff to maintain the smooth running of the practice and there were enough staff on duty to keep patients safe. There was an arrangement in place for members of different staff groups to cover each other's annual leave.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included accident reporting, checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Staff we spoke with told us that they were aware of these procedures and were able to demonstrate the correct action to take if they recognised risks to patients. For example, they described how they would treat and escalate concerns about adults or children or a patient who was experiencing a physical or mental health issue or crisis. A number of staff we spoke with told us about how they responded to an emergency situation at the practice recently which had been raised as a significant event.

The practice had a health and safety policy and there was an identified health and safety lead. We noted that there were documented checks of the premises and areas for action had been identified and completed. For example unsuitable chairs had been replaced with new ones and separate areas had been identified for 'clean' and 'dirty' storage. We saw that any newly identified risks, including risks to patients, significant events, complaints or infection control were discussed at the weekly multidisciplinary meetings.

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told that all staff had undertaken basic life support training. We looked at four staff files, which showed that this had been completed and staff we spoke with confirmed this. Emergency equipment was available including access to oxygen and an automated external defibrillator. This is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Oxygen is widely used in emergency medicine, both in hospital and by emergency medical services or those giving advanced first aid. Having immediate access to

Good

Are services safe?

functioning emergency oxygen cylinder kit helps people survive medical emergencies such as a heart attack. Staff we spoke with all knew the location of this equipment and records confirmed that it was checked weekly.

Emergency medicines were available at the practice and included those for the treatment of cardiac arrest, anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated) and hypoglycaemia (low blood sugar). Staff we spoke with knew of their location. Processes were also in place to check whether emergency medicines were available and within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use. Medicines were locked away at night. However there was no record kept of the quantity of emergency medicines kept in stock and there was a risk of unauthorised access. We noted that the room they were locked in was warm and there were no checks or records of room temperatures taken to ensure the medicines were stored within the acceptable ranges.

A business recovery plan, dated July 2015 was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Risks identified included loss of building, loss of the computer system, loss of medical records, incapacity of GPs and staff and loss of the electricity supply. The document also contained relevant contact details for staff to refer to.

The practice had a fire safety policy and had carried out a fire risk assessment, dated 29 June 2015, that included actions required to maintain fire safety. The required actions had been implemented by the practice. For example a floor plan was now available in a red folder in reception. We saw records of regular checks of the fire equipment, fire alarm and emergency lighting. Records showed that the majority of staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. These were shared by email and hard copy and were also shared at weekly multidisciplinary meetings. There were a number of protocols specifically for the practice which were based on best practice guidelines. The staff we spoke with confirmed that patients 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 best practice and these were reviewed when appropriate.

There were clinical leads for a number of long term conditions. If a patient had complex needs they would be seen by the GP who was the clinical lead in that long term condition. An advanced nurse practitioner led on chronic disease management with nurses who specialised in clinical areas such as asthma and diabetes. Patients told us that they were reviewed regularly for their long term conditions. This included patients who lived in care homes. Care plans were in place for patients with chronic obstructive pulmonary disease and rescue packs were issued, so patients had immediate access to emergency medicines which reduced the need for a hospital admission. There was also a nurse led diabetes clinic and a diabetes specialist nurse held a monthly clinic at the practice for those patients with complex diabetes.

The practice had a robust process in place for referrals to be made and monitored. We were told that informal peer review of referrals was made at the weekly multidisciplinary team meetings to ensure their quality and appropriateness. The practice worked closely with the Clinical Commissioning Group (CCG) who compared practice performance against other practices in the CCG area. This included prescribing, referrals, accident and emergency attendance and unplanned admission data. We found that in all areas they performed in line with other practices. Where they had higher than average data, there were justifiable reasons for this.

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

There was evidence of effective structuring of patient records which was undertaken by clinicians. This included the use of templates for a range of clinical conditions, which included for example chronic obstructive pulmonary disease, cardiovascular disease and diabetes. This ensured that care and treatment provided was comprehensive, standardised and took into account best practice guidance.

The practice had a system in place for completing clinical audit cycles. A clinical audit is an assessment of clinical practice against best practice, for example clinical guidance, in order to measure whether agreed standards are being achieved, and to make recommendations and take action where standards are not being met. The practice showed us a number of clinical audits where there had been completed cycles, where recommendations had been implemented and the audit repeated to ascertain if there had been improvement. The audit we looked at showed that there had been some improvement to the quality of care patients received.

GPs in the practice undertook minor surgical procedures. However during the inspection we found they were not registered for this regulated activity. The provider took immediate action in order to register for this. We found that GPs who undertook minor surgical procedures were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits of their results and used that in their learning.

We saw evidence that patients had received a medication review, which was in line with the expected time dependent on their presenting condition. The patients we spoke with confirmed that their medicines were reviewed regularly. This was also confirmed by the representatives we spoke with from the care homes where patients were registered with the practice.

There was also a process in place for following up patients who did not attend for their appointment. We were told

Good

Are services effective?

(for example, treatment is effective)

that the practice were proactive in telephoning patients to arrange a convenient time if they were offered an extended appointment, in order to maximise patients attending for their appointment.

Effective staffing

The practice had an induction checklist which was used for all new staff starting work. This was adapted to their previous experience and skills. This covered a range of areas including introduction to the team, building security, health and safety, confidentiality, training, personal development and reviews and policies and procedures. We were told that new staff underwent a period of induction when they first started to work at the practice. We looked at four staff files and found completed and signed induction records. Staff we spoke with confirmed they received an induction which they had found useful. We also saw that competency checks were undertaken for nurses and health care assistants and these were recorded.

The practice staff included medical, nursing, managerial and administrative staff. We reviewed four staff files and saw that staff had undertaken training, such as basic life support, safeguarding, information governance and equality and diversity. The practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

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

The practice had an appraisal policy and process in place for its staff. The majority of staff had received an appraisal in the previous year. Two staff had their appraisal scheduled for the week after the inspection. We noted that one of the GPs had undertaken the appraisals for all staff. Staff we spoke with confirmed they had received an annual appraisal, that they found it supportive and useful and felt valued having a GP undertake their appraisal. Appraisal records we looked at showed that a review of staff members' performance had been undertaken. Areas for improvement and future training needs had also been identified and planned for.

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 and the 111 service both electronically and by post. The GPs were responsible for reviewing their own correspondence and had a buddy system in place so another GP covered this when they had a day off. They also had a duty GP who dealt with all the correspondence for GPs who were on annual leave. Non-clinical staff we spoke with confirmed that any clinical issues were referred to a GP or clinician to act upon.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract.) The practice had identified protected time for one of the nurses to follow up all patients who had an unplanned admission to hospital. They were reviewed and appropriate support provided, which often included emotional support. The most vulnerable patients had a care plan in place and were reviewed on a quarterly basis. The practice was not able to show if this had reduced unplanned admissions, however they were clear that patients had found the service beneficial.

The practice held weekly multidisciplinary team meetings to discuss the needs of patients with complex needs, for example those with end of life care needs, those who were vulnerable and those patients who were less engaged in their care. These meetings were attended by GPs, nurses, administration staff, district nurses, community matron, social services and the palliative care team. There was also an open invitation for health visitors and midwives to attend when necessary and this usually happened on a monthly basis. The practice had a palliative care register and palliative care meetings were held every six to eight weeks to discuss the care and support needs of patients and their families. This included sharing do not attempt resuscitation decisions and patients' preferred place of care decisions. All patient deaths and recent admissions were reviewed. We were advised by the practice manager that the cancer emergency admission rate was lower than

Good

Are services effective?

(for example, treatment is effective)

the Clinical Commissioning Group (CCG) average. One of the GPs was the local Macmillan GP and retained GP at the CCG for cancer and palliative care. They had been involved in writing best practice guidelines.

Information sharing

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.

The practice maintained registers for patients with palliative care needs, those identified as vulnerable or frail and patients with mental health conditions or those with learning disabilities. GPs and nurses at the practice worked closely with other agencies to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs. The practice worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment for all patients, where this was appropriate.

Staff were alert to the importance of patient confidentiality and the practice had appropriate policies and procedures in place for handling and sharing patient information.

Consent to care and treatment

We saw that the practice had a consent protocol. The clinicians we spoke with described the processes to ensure that consent was obtained and documented from patients whenever necessary, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients we spoke with, and received comments from, confirmed that they were provided with information in order to make a decision and that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. The clinical staff we spoke with demonstrated an understanding of Gillick competency test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The practice had Mental Capacity Act policy available for staff. The Mental Capacity Act (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The GPs and nurses we spoke with were knowledgeable about the Mental Capacity Act 2005 and their duties in fulfilling it. The majority of these staff had received training in this area and they understood the key parts of the legislation. They were able to describe how they implemented it in their practice and gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

Patients who needed support from nominated carers were identified on their patient record. Where this information was known, clinicians ensured that carers' views were listened to as appropriate. This was supported by the patients we spoke with during the inspection and from the feedback from the representatives of patients who lived in care homes.

Health promotion and prevention

There was a large range of up to date health and health promotion information available at the practice and on the practice website, with information to promote good physical and mental health and lifestyle choices. The practice website referred patients to a range of information supplied by NHS Choices and Patient.co.uk. This included information on men's health, mental health, child health and a range of medical conditions. Health promotion information was also provided on screens in the waiting areas at the practice.

We saw that new patients were invited into the surgery when they registered, to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. The new patient health check was undertaken by a health care assistant or a nurse. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP in a timely manner. NHS health checks were offered to all patients between the ages of 40-74 years to support the early identification of chronic disease. Appointments were also available with a nurse for advice on smoking cessation, weight reduction and healthy lifestyle. We saw that chlamydia screening kits were easily available in the entrance area of the practice. A health trainer, a care support worker and the alcohol and drugs support service hold clinics at the practice weekly.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support. The practice kept a register of all patients with a learning disability and offered them an annual health check. On the day of our inspection, we were told that 19 of the 42 patients with a learning disability (46%) had attended for an annual health check in the previous year. The practice had completed an audit in June 2015 and were aware of the need to ensure patients who had not received an annual health check were offered one and that those who did not attend were recalled in line with the protocol.

We looked at the most recent Quality and Outcomes Framework (QOF) data and noted that the practice had scored higher than the Clinical Commissioning Group (CCG) and England average for cervical screening (100%) and blood pressure (100%). They scored the same as the CCG and above the England average for child health surveillance (100%) and maternity services (100%). They had scored the same as the CCG average and below the England average for contraception (90.1%). They scored below the CCG and England average for the primary prevention of cardiovascular disease (33.3%) and smoking (84.9%). They scored 100% for obesity which was the same as the CCG and England average. We did note the low exception rate (the number of patients excluded from the data) for the practice, which was 5.1%. This was lower than the CCG average, which was 8.7% and the England average, which was 7.9%. Patients can be exception-reported for various reasons, for example if they are newly diagnosed, newly registered with a practice, if they do not attend appointments or where the treatment is judged to be inappropriate by the GP. They can also be exception-reported if they decline treatment or investigations. The practice told us that these scores were likely to have improved as they had broadened the clinical areas where patients were recalled and had restructured their chronic disease management so that the nurses had additional responsibility in this area.

Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. Nurses administered flu vaccinations to housebound patients and at a local traveller site. They also offered flu vaccinations to carers. Clinical staff we spoke with told us about the arrangement in place for following up patients who did not attend for their immunisations. The practice had a good uptake, which was above 92% for the majority of childhood immunisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a patient centred culture at the practice. All staff we observed and spoke with were committed to working in partnership with patients. During our inspection we overheard and observed friendly and caring interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. We spoke with seven patients and reviewed 64 CQC comment cards which had been completed by patients to tell us what they thought about the practice. Patients told us that staff were caring, they were treated with respect and their privacy was maintained.

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

We spent time in the waiting room and observed a number of interactions between the reception staff and patients coming into the practice. The quality of interaction was consistently good, with staff showing genuine empathy and respect for patients, both on the phone and face to face. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Patients we spoke with told us that they were satisfied that their confidentiality was maintained by all staff.

The reception was located to one side of one of the largest waiting room area. There was a notice asking patients to respect other patients' privacy. Staff we spoke with told us that they would take patients to a private room if they were upset or if the patient started to share sensitive information. However there was no notice informing patients that they could request this. One receptionist told us they had used the private room to support a homeless patient to register at the practice.

We looked at data from the National GP Patient Survey, which was published on 2 July 2015. 271 surveys had been sent out with 106 being returned, which was a response rate of 39%. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (92%) and for whether nurses listened to them, 92% reported this as being good or very good. Satisfaction rates for patients who thought they were treated with care and concern by their GP was 90% and for whether the GP listened to them, 89% reported this as being good or very good. 77% of respondents described their overall experience of the practice as fairly good or very good and 86% of patients stated they would recommend the practice. These results were in line with or above average when compared with other practices in the CCG area and the national average.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt fully involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patients reported they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive and did not feel rushed. We heard examples of where options for treatment had been explained in a way that patients understood. Patient feedback on the comment cards we received was also positive and aligned with these views. Representatives from the care homes we spoke with confirmed that the GPs and practice nurses involved patients in care and treatment decisions and in their care plans.

Data from the national GP patient survey, published on 2 July 2015, showed 89% of practice respondents said the GP involved them in care decisions, 90% felt the GP was good at explaining tests and treatments and 92% said the GP was good at giving them time. These results were all above average when compared with other practices in the Clinical Commissioning Group (CCG) area and nationally. In relation to nurses: 88% said they involved them in care decisions; 95% felt they were good at explaining tests and treatments and 92% said they were good at giving them enough time. These results were in line with the CCG and national average.

Patient/carer support to cope emotionally with care and treatment

When a new patient registered at the practice they were asked if they were a carer or had a carer and the practice

Good

Are services caring?

identified them on the computer system. Patients could also identify themselves as a carer and who they cared for, via the practice's website. Information for carers, in the form of leaflets and posters were displayed in the waiting room. These provided information on a number of support groups and organisations that could be accessed for patients, relatives and carers. Information for carers was also available on the practice's website and included for example, caring for a parent, support groups, taking a break, housing and finance.

A carers' support worker was available at the practice on a weekly basis to provide advice and support, which included benefits advice. Appointments could be made at the practice or carers were able to turn up on the day and would be seen. We saw evidence that the practice were also planning a carers' event for September 2015, which will involve Mind, Alzheimer's Society, Carers Agency Partnership, Age Concern and Social Services. A community advocate attended the practice every two weeks to provide support and advice to patients. This was initially set up to ensure patients with long term conditions were well supported in order to reduce unplanned admissions to hospital. However this had successfully developed to include signposting for all patients. This included for example, signposting to benefits and transport advice, companionship classes, sporting activities and addressing loneliness.

Staff told us that if families had suffered bereavement, they were sent a letter offering the practice's condolences. If the GPs felt that a home visit was needed, then this was undertaken by the most appropriate GP. In addition to the support provided by the practice staff, we were told that patients were referred to local external organisations that provided specialist services. We noted that all deceased patients were discussed at the weekly clinical meeting to identify if there was anything that could be learnt or done differently.

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 practice had received a significant increase in patient registrations since January 2015, going from just below 9700 to just above 10200 in June 2015. The practice had identified the need to increase nursing and GP capacity, and administration capacity for summarising patient care records and had achieved this or were on target to achieve this. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs.

There had been little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. The practice staff endeavoured to book appointments for family members at similar times for patients' convenience. Longer appointments were available for patients who needed them, which included patients with multiple chronic diseases. Home visits were available to patients who could not attend the practice. Patients we spoke with on the day of our inspection told us they were satisfied that the practice was meeting their needs. Comment cards left by patients visiting the practice prior to our visit also reflected this.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the virtual patient reference group (PRG). A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PRG were consulted on the areas they would like to see included in the annual patient survey. The 2014 to 2015 patient survey identified priorities for improvement which included: improved staff knowledge to advise patients on the services available to them; updated and improved practice website; more eye catching displays on the notice boards; improved use of the telephone system to advertise services when patients called; more regular updates on the practice's Facebook page and a one off newsletter to include in patient recall letters and new patients packs. We saw evidence and staff confirmed that improvements had been made in these areas. For example we saw that three different newsletters for patients had been produced.

Tackling inequity and promoting equality

The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. Training records that we looked at confirmed that staff had received training in equality and diversity. During the inspection staff provided a number of examples where they had made reasonable adjustments to ensure patients were not discriminated against. We were given examples of when this had happened for patients with a learning disability. Staff confirmed that they supported patients who were not be able to read or write to register at the practice. The practice had a flexible approach to patients who found waiting for an appointment difficult due to anxiety. Staff told us that translation services were available for patients who did not have English as a first language, although they had not needed to use these very often. There was a self-check in screen which could be accessed in different languages.

The practice was purpose built and there were automatic opening doors at the entrance. Ground floor consulting rooms were provided, with a lift to the first floor consultation rooms. There were wide corridors and the waiting areas and consultation rooms were easy to access for those patients with mobility needs and those who used prams. Accessible toilet facilities were available for all patients attending the practice, which included baby changing facilities. A room was available on request for mothers and babies who needed to breast feed.

Access to the service

The practice opened between the hours of 8am and 6.30pm, Monday to Friday with additional hours until 8pm on a Monday. This was particularly useful to patients who found it difficult to attend during working hours. Information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange routine and short notice appointments, and home visits. Appointments could be booked by telephone, in person or online. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

The practice had nominated GPs for registered patients who lived in care homes. We spoke with representatives

Good

Are services responsive to people's needs?

(for example, to feedback?)

from two care homes who confirmed that a named GP visited weekly. They also advised that if a patient needed to be seen urgently then they could request a home visit and the GP would visit. There was a dedicated telephone number for care homes and the ambulance service to call if they wanted to speak with a GP.

We looked at data from the National GP Patient Survey, which was published on 2 July 2015 and found that 86% of patients described their experience of making an appointment as good and 94% said the last appointment they got was convenient. These results were the same as or above average when compared with other practices in the Clinical Commissioning Group and nationally. Comments received from patients on the day of the inspection showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. They confirmed that they could see another doctor if there was a wait to see the doctor of their choice. We noted that routine appointments with clinicians were available on the same day. The care home representatives we spoke with confirmed that requests for home visits were responded to in a timely way.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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. There was information on making a complaint in the practice's patient information leaflet, on the practice's website and in the practice's complaint leaflet. The practice's complaint leaflet was not on display and had to be requested from reception staff. We spoke with the GP partners about this and they advised they would ensure this leaflet was easily available to patients. The practice's complaints leaflet, did not contain any information of how to escalate complaints to the Parliamentary and Health Service Ombudsman (PHSO), if patients remained dissatisfied with the practice's response to their complaint. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint but they believed that any complaint would be taken seriously.

The practice had received 24 complaints from 1 April 2014 to 31 March 2015, the majority of which were written. We reviewed the complaint summary and found that complaints had been dealt with in a timely way and an apology had been given where this was appropriate. We reviewed one complaint in depth and found this had been acknowledged, investigated and a response had been sent to the complainant within two days. The response letter also advised the patient that lessons had been learnt and the staff involved had had the complaint discussed with them in order to improve their practice.

The practice discussed and reviewed complaints at the weekly multi-disciplinary team meetings in order to identify areas for improvement. These were shared with the individuals involved. All outcomes from complaints were recorded on the multi-disciplinary team minutes and emailed to all attendees and team leaders, who further disseminated any learning outcomes. The practice had implemented learning from complaints to improve the service offered to patients.

Are services well-led?

Good

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

Our findings

Vision and strategy

The aim of the practice was to provide the best possible care to patients whilst maintaining an efficient and professional workforce. They also had a number of objectives clearly stated in order to achieve this aim. We spoke with a number of staff and they all had an awareness of the aims and objectives and knew what their responsibilities were in relation to these. We spent some time observing staff and saw evidence that these objectives were demonstrated in their interactions with colleagues and patients. We noted that the standards that patients could expect from the practice were provided in the practice's patient information leaflet and on the practice's website.

The practice management team had successfully recruited according to an anticipated and actual increase in demand and we were told that they did not have difficulty recruiting GPs to the practice. For example they had recruited three additional administration staff and two additional GPs, in response to the increase in list size, which was approximately 500 new patients in nine months. They had actively considered potential future possibilities for the practice. These included for example, improvements needed to the building and the potential increase to the patient population. Whilst no decisions had been made about these areas, this showed that the team were proactive in ensuring they were in a positive position to respond to any future changes.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available both electronically on the computer system and in paper copy. All the staff we spoke with knew where to find these policies. We looked at ten of these policies and procedures and they had been reviewed and were up to date. There was a process in place for policies to be reviewed and agreed before being implemented.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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 QOF data for this practice showed they achieved an 86.8% score (of total available points) which was slightly lower when compared with the local Clinical Commissioning Group average of 91.5% and the England average of 94%. We did note the low exception rate (the number of patients excluded from the data) for the practice, which was 5.1%. This was lower than the CCG average, which was 8.7% and the England average, which was 7.9%. Patients can be exception-reported for various reasons, for example if they are newly diagnosed, newly registered with a practice, if they do not attend appointments or where the treatment is judged to be inappropriate by the GP. They can also be exception-reported if they decline treatment or investigations. The practice told us they were aware of these scores and had taken action. We were advised these scores were likely to have improved as they had broadened the clinical areas where patients were recalled and had restructured their chronic disease management so that the nurses had additional lead responsibility in this area.

The practice had arrangements for identifying and managing risks. Any risks were dealt with by the lead for that department and if they could not be resolved they were discussed between the practice manager and the GP partners at the weekly meeting. The practice had arrangements for identifying, recording and managing significant events and a system for the management of complaints.

We noted during our inspection that GPs in the practice were undertaking minor surgical procedures, although they were not registered with the CQC for this. We spoke with a number of partners and the practice manager who advised that this was an oversight. They took immediate action to apply for registration with the CQC for this regulated activity.

Leadership, openness and transparency

There was a clear management and clinical leadership structure with named members of staff in lead roles. For example, there was a lead for complaints, health and safety, information technology and human resources. There was also a lead nurse for infection control, a lead GP for diabetes, palliative care, prescribing and care homes. There was a balance in the clinical direct patient work and the external work that GPs engaged in which included having lead roles in the Clinical Commissioning Group (CCG). The practice manager had an extended role at the CCG which helped the practice to keep updated about

Are services well-led?

Good

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

current and future developments. The staff we spoke with reported a good work life balance, which members of the leadership team felt had been a significant factor in their successful recruitment record. We spoke with a number of clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any questions or concerns.

There were a number of meetings held at the practice in order to share information and provide support for staff. These included separate meetings for groups of staff, including nurses and whole practice team meetings. The practice manager and the GP partners also met 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 with the practice manager, or the GPs.

The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was low turnover of staff. Staff and external representatives we spoke with told us that the leadership of the practice was calm, open, friendly and approachable. We also found evidence of this during the inspection.

Seeking and acting on feedback from patients, public and staff

We found the practice listened and responded in a timely way to formal and informal feedback from patients. Feedback from patients had been obtained through patient surveys, the friends and family test, the virtual patient reference group and complaints.

The practice had a virtual patient reference group (PRG). (This is a group of patients registered with a practice who work with the practice to improve services and the quality of care.) The practice had made improvements based on the finding of the patient survey undertaken in 2014 to 2015. The results and actions agreed from this survey were available on the practice's website.

The practice collated feedback from patients from the 'friends and family' test, which asks patients, 'Would you recommend this service to friends and family?' The friends and family feedback form was easily accessible in the practice for patients to complete. We were provided with the following data from the practice. 11 responses had been received in January 2015, 26 responses were received in February 2015 and in March 2015, 34 responses were received, all with 100% recommending the practice. In April 2015, 38 responses were received, with 97% recommending. In May 2015, 44 responses were received with, 96% recommending and in June 2015 57 responses were received with 98% recommending the practice. The practice had encouraged patients to complete the friends and family feedback forms and this was evident in the increasing response rates.

The staff we spoke with described the working environment as caring and supportive and that they felt valued. We were told they felt that any suggestions they had for improving the service were taken seriously and staff told us they were listened to. An example of this was a blog which was used as a means of informal communication to the staff. This covered 'little' things like a desk move in an office, which did not warrant staff being informed formally, but ensured staff knew what was occurring in the practice. Staff reported that they found this useful. 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 and in paper copy. Staff told us they with were aware of the whistleblowing policy. Staff we spoke with felt that they were easily able to raise any concerns and that they would be listened to.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through both formal and informal training and mentoring. They commented positively on the clinical support they could easily obtain from the GPs and each other. The nurses we spoke with told us they regularly attended or received feedback from external clinical meetings. The practice also closed for staff training for half a day on a quarterly basis. Staff confirmed that regular appraisals took place and learning needs were identified and met. There was a culture of a willingness to improve and learn across all the staff we spoke with.

The practice was a GP teaching practice and supported GP Registrars, who were qualified doctors training to be GPs and medical students who were training to become doctors. We spoke with one GP registrar, who told us they were provided with tutorial time with the GP trainer, had training from GPs with special interests and had access to

Are services well-led?

Good

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

all the GPs for advice and support. They told us they felt very well supported to learn in a friendly, calm and relaxed environment. They gave positive feedback on the clinical expertise of the GPs.

The practice had completed reviews of significant events and other incidents and shared with staff both informally and formally at meetings to ensure the practice improved outcomes for patients. Compliments and positive responses from patients were shared with the practice team. The results of patient surveys were also used to improve the quality of services. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care.