Ormesby Village Surgery

Quality Report

Also known as (Ormesby Village Surgery).
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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

On 21 October 2014 we carried out an announced inspection of Coastal Villages Practice (Ormesby Village Surgery), Ormesby, Great Yarmouth, Norfolk, under our new approach of inspection of primary medical services. The practice had three branch surgeries, two of which were included in our inspection.

We found that the practice was good overall across all the areas we inspected.

Our key findings were as follows:

- The practice was safe, well led, effective, caring and responsive.
- Staff recognised and understood the needs of patients and tailored access to care and treatments to meet these needs.
- The practice was working in partnership with other health and social care services to deliver individualised care.
- The practice provided a safe service in an environment which was well managed and risks to staff and patients were identified and minimised.
- Staff were trained and supported to deliver high quality patient care and treatment and to improve outcomes and experiences for patients

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

Importantly, the provider should:

- Ensure there is an effective review of complaints handling and procedures in place to ensure that where appropriate a significant event review is put in place alongside the complaints procedure.
- Ensure there are suitable security arrangements in place for the safe storage of medicines in clinical areas and all associated prescribing forms and paperwork across the practices.
- Ensure that all staff who may be used for chaperoning services were informed about their role and the implications for protecting both the patient and the GP as a chaperone.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was safe. There were systems in place to safeguard vulnerable patients from the risk of harm. Safeguarding policies and procedures were in place for both children and vulnerable adults. This enabled staff to recognise and act on concerns in relation to abuse. There were clear accountabilities for significant event reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents. We saw how incidents were recorded and investigated.

The practice had a robust process in place for recruiting staff to work. This included checking the registration of nurses and GPs. There were effective systems in place to minimise the risk of infection. There was appropriate and sufficient emergency medical equipment and medicine available.

Are services effective?

Good

The practice was effective. There were procedures in place to deliver care and treatment to patients in line with the appropriate standards. Systems to improve the management and access for patients to health reviews of their long term conditions were implemented. There were joint working relationships with community services and engagement with health and social care providers to co-ordinate care and meet people's needs.

Are services caring?

Good

The practice was caring. Patients and carers we spoke with described the service provided as good. The patients we spoke with felt they were listened to and respected. Patients told us they were involved in decisions about their care and treatment. Patients told us they were treated with dignity and respect by both the non-clinical and clinical staff.

Are services responsive to people's needs?

Good

The practice was responsive to people's needs. The practice worked effectively with other health and social care services to ensure patients received the best outcomes. We found that the practice understood the individual needs of patients and made reasonable adjustments accordingly. The practice sought engagement with patients to gather feedback on the quality of the service provided and responded to the feedback in order to improve the service.

Summary of findings

Are services well-led?

Good

The practice was well-led. There was a clear leadership and management structure. The partners and the practice and business managers we spoke with understood how they needed to take forward the practice in the future to improve patients' experiences. There was a commitment to learn from feedback, complaints and incidents. The appointment system had been restructured to improve efficiency and meet patients' expectations and this was reviewed daily. We saw that staff had an annual appraisal to enable them to reflect on their own performance with the aim of learning and improving the service. Staff told us they felt well supported. There was evidence of a range of team meetings. There was an emphasis on seeking to learn from stakeholders, in particular through the local clinical commissioning group (CCG) and the patient participation group (PPG). This is a group of patients registered with the practice who have an interest in the service provided by the practice.

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

Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. The recall system had been set up to coincide with the month of the patient's birthday for blood tests and health care reviews, we were told this made it easier for patients to remember when their review was due.

Older patients had a named GP responsible for their overall care and a care plan. Patients had been sent a care plan pro-forma to identify any carers, social services contacts, community services including community nurses and matrons and information regarding the patient's next of kin. Patients had been contacted by their GPs to discuss their preferred place of care, their resuscitation wishes and understanding their medicines. These were reviewed every three months with the patient.

Care homes in the practice catchment area had an assigned GP who attended the homes weekly for ward rounds and was accessible for advice and support when required.

There was an awareness amongst the staff team that the local elderly population were striving to maintain independent living, either alone or with elderly partners. Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made.

People with long term conditions

Good

The practice offered relevant care to patients with long term conditions which included blood tests, blood pressure monitoring, electro cardiography (ECG) (a test that measures the electrical activity of the heart) and flu vaccinations. There was a named GP lead for chronic diseases who was working with the lead nurse in setting up specialised clinics. This also ensured up to date guidelines and templates (a system for recording observations and tests on patient's' records) were available for the wider nursing teams. The practice offered nurse led chronic obstructive pulmonary disease (COPD) and diabetes health checks and patients with these conditions were seen at least annually for a health and medication review. The recall system for people with long term conditions had been set up to coincide with the month of the patient's birthday for

blood tests and other reviews, we were told this made it easier for patients to remember when their review was due There was support and education provided to patients with conditions such as diabetes or obesity.

The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. Staff from the community palliative care team and the district nurses attended meetings with the GPs and the nursing staff, which enabled practice staff to discuss the needs of patients with chronic and terminal illness. They discussed arrangements for individual patients on advanced care plans and ensured the out of hours service was informed of the care arrangements when the practice was closed.

The practice was caring in the support it offered to patients with long term conditions. For example the practice provided care to local care homes. The care this group of patients received was monitored and kept under review by the GP lead. The practice was responsive in prioritising urgent care that patients required and the practice worked towards improving outcomes for patients with long term conditions and complex needs.

Families, children and young people

Good

The practice offered lifestyle advice to pregnant patients. The practice worked with local midwives and health visitors to offer a full health surveillance programme for children. Expectant mothers attending the practice were seen for their initial antenatal assessment and then referred to the midwife who held weekly clinics at the practice. Mothers were seen routinely for a postnatal check at the six to eight week stage.

Babies were seen at the baby clinic within the practice where they were checked and given their first immunisations. Checks were also made to ensure the maximum uptake of childhood immunisations. Health and advice checks were available for young patients.

The practice provided a weekly contraceptive implant clinic service to patients across all sites and a monthly intrauterine coil (IUCD) clinic was also available. This ensured patients had easy access to long acting reversible contraception's (LARC).

Working age people (including those recently retired and students)

Good

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. Appointments could be booked in person, by telephone or via the practice website. Appointments could be

Summary of findings

booked up to six weeks in advance. The practice offered late evening opening times till 8pm on Wednesdays at the Ormesby surgery and Thursdays till 8 pm at a branch surgery to provide easier access for patients who were at work during the day.

Patients were offered a choice when referred to other services. Information about annual health checks for patients aged between 40 and 74 years was available within the practice and on the website. The practice provided travel vaccination clinics with a practice nurse. Patients with caring responsibilities and those who required additional support were identified and this was recorded on their patient record. The practice offered access to the Wellbeing Service for psychological support for all patients when required. The Wellbeing Service provides a range of psychological interventions to help and support people with common mental health problems and negative emotions such as low mood, anxiety, depression or stress.

People whose circumstances may make them vulnerable

Good

The practice was accessible for any vulnerable group. The practice had identified patients with learning disabilities. Patients were encouraged to participate in health promotion activities, such as smoking cessation, cervical and breast cancer screening. The practice offered telephone consultations for those patients identified as having verbal communication issues. The practice used a telephone translation line to provide a confidential translation service to people whose first language was not English. The practice used notes alerts and Special Patient Notes (SPNs) on patient's' medical records. This information could be accessed by the A&E and 111 services if they needed to access a patient's medical records in an emergency when the practice was closed. There was a hearing loop available at all the practice sites for those patients with limited hearing.

The practice had systems in place to ensure access to the Summary Care records for temporary residents. This ensured the practice was able to access the medical records and information of all temporary residents and provide the best standards of care to anyone not registered with the practice. For example, travellers, the homeless and holiday makers. The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record

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

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). Care was tailored to patients' individual needs and circumstances, including their physical health needs. Staff knew how to recognise and manage referrals of more complex health needs and the practice included other health professionals at their practice meetings when required. Staff were encouraged to be aware and to raise any concerns should a patient appear in distress or forgetful. Annual health checks were offered to people with severe mental illnesses. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. The practice ensured that patients with poor mental health were able to access the practice at a time that was suitable for them. Annual health checks were offered to people with dementia. Carers were involved in the reviews as necessary. Patients on regular medication were always invited for a medication review before their prescription was repeated. Information was shared with other health and social care professionals and information and signposting was available through the practice website and leaflets in the surgery. The practice offered access to the Wellbeing Service for psychological support when required. The Wellbeing Service provides a range of psychological interventions to help and support people with common mental health problems and negative emotions such as low mood, anxiety, depression or stress.

Summary of findings

What people who use the service say

We spoke with 14 patients during our inspection. This included representatives from the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the

Inspection and had displayed our poster in the waiting room. Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 20 comment cards, all contained detailed positive comments about the caring and compassionate attitude of the staff. Comments cards also included positive comments about the cleanliness of the practice, the skills of staff, the way staff listened to their needs and being pleased with the on-going care arranged by practice staff. These findings were also reflected during our conversations with patients.

The feedback from patients was very positive. Patients told us about their experiences of care and praised the level of care and support they received at the practice and from the practice team. The patients we spoke with said they were very happy and felt their treatment was very good. Patients we spoke with told us the GPs and nurses always gave them plenty of time during the consultation to explain things. We were told the clinicians were kind with the patients and there had been effective communication between the GPs at the practice and other services. Patients told us the GPs and nurses were supportive and they thought the practice was well run. Patients knew how to complain. but we were told they had no complaints.

Patients told us the appointment system had improved and they could get an appointment when it was convenient for them. They told us that they were able to make same day appointments or pre-book in advance. The majority of patients said that they could always be seen by the GP of their choosing. Some patients commented that this sometimes meant waiting for an appointment. We were told they liked the continuity of care they received. Patients told us they felt the staff respected their privacy and dignity and the GPs were approachable and supportive.

Patients we spoke with told us they were happy with the dispensary and the supply of repeat medicines and prescriptions. In addition they reported no delays in obtaining their medicines. We were told they were happy with the practice facilities and would recommend the practice.

There was a supply of health care and practice information on display around the waiting room area.

Areas for improvement

Action the service SHOULD take to improve

Ensure there is an effective review of complaints handling and procedures in place to ensure that where appropriate a significant event review is put in place alongside the complaints procedure.

Ensure there are suitable security arrangements in place for the safe storage of medicines in clinical areas and all associated prescribing forms and paperwork across the practices.

Ensure that all staff who may be used for chaperoning services were informed about their role and the implications for protecting both the patient and the GP as a chaperone

Ormesby Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and a patient expert by experience (these are people who have experience of using health and social care services).

Background to Ormesby Village Surgery

Coastal Villages Practice (Ormesby Village Surgery) is located in the rural town of Ormesby St. Margaret in Norfolk. The practice provides services for approximately 17500 patients living in the area. The practice is situated in a purpose built surgery and shares its accommodation with a dental surgery. There were accessible toilets and disabled car parking facilities. Coastal Villages Practice is a training practice and encourages and facilitates the training of GPs. The practice offered dispensing facilities at the Hemsby and Martham branch surgeries.

The practice is open between 8am and 5.30pm Monday, Thursday and Friday. On Tuesdays and Wednesday the practice closed at 1pm, however appointments were available at the branch surgeries. The practice offered extended hours appointments from 6.30pm to 8pm on Thursday evenings and Tuesday evenings from the Hemsby branch surgery. Same day and pre-booked advance appointments could be made in person, by telephone or online.

The practice has a team of 12 GPs meeting patients' needs. Eight GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there are four salaried GPs, two senior practice nurses, eight registered nurse prescribers, five healthcare assistants who also see patients for phlebotomy consultations (specialised clinical support workers or health care assistants who are trained to draw blood from patients for examination), a practice pharmacist and three ACT pharmacy technicians (accredited checking technicians), a team of receptionists and administrators, a practice manager, a business manager and an IT manager and a team of cleaners.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, counsellors, support workers, health visitors and midwives.

The practice provides services to a diverse population age group, in a semi-rural location. The practice has three branch surgeries. These were situated at Hemsby Medical Centre, 1 Kings Court, Hemsby, NR29 4EW. Martham Health Centre, Hemsby Road, Martham NR29 4QG and North Caister Medical Centre, Branford Road, Caister On Sea. We visited each of these sites as part of our inspection.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Coastal Villages Practice (Ormesby Village Surgery) does not provide an out-of-hours service to patients. Outside of practice opening hours a service is provided by another health care provider (South East Health) by patients dialling the national 111 service. Details of how to access emergency and non-emergency treatment and advice were available within the practice and on its website.

Detailed findings

Why we carried out this inspection

We inspected Coastal Villages Practice (Ormesby Village Surgery) as part of our new comprehensive inspection programme.

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

This provider had not been inspected before and that was why we included them

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

How we carried out this inspection

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

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

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

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

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 21 October 2014. During our inspection we spoke with a range of staff including GP partners, salaried GP's, practice nurses, health care assistants, the pharmacist, dispensers, reception and administrative staff and the practice and business managers. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members and reviewed personal care or treatment records of patients. We reviewed 20 comment cards where patients and members of the public shared their views and experiences of the service.

We looked at records and documents in relation to staff training and recruitment. We conducted a tour of the premises and looked at records in relation to the safe maintenance of premises, facilities and equipment.

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate that they had maintained a good track record on safety. We saw records to show that performance had been consistent over time and where concerns had arisen, for example with a prescribing error, complaint or a safeguarding concern, they had been addressed in a timely way. The manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We found the learning from safeguarding reviews was communicated internally at the quarterly significant event and monthly practice meetings and through the practice shared drive. This is a system that allows staff access electronically from any computer at any of the practice locations to documents and information such as the practice policies, contact names and addresses, telephone numbers for local services, staff rotas, training information and other documents. In addition any learning from safeguarding reviews were shared externally at the quarterly multi-disciplinary team (MDT) Vulnerable and End of Life patients meetings. Staff told us that at the Vulnerable and End of Life patients meetings, the care and treatment of individual patients was discussed and outcomes were reviewed to establish if the practice could have done things differently. We saw the practice had learnt when things had gone wrong and put systems in place to improve safety and standards. However we noted that there were some incidents of complaints that potentially could have been reviewed as significant events for example missed diagnosis. We discussed this with the GPs and practice manager who agreed to undertake an in-depth review of complaints as significant events following the inspection.

Reliable safety systems and processes including safeguarding

Staff were able to demonstrate how they would access the practice safeguarding policies and procedures. We were told staff received changes and updates via emails from the practice manager, via the practice intranet and through attending practice meetings, clinical meetings, and Vulnerable and End of Life Patients meetings where safeguarding concerns were discussed. Clinicians told us the monthly clinical meetings were useful and enabled working in partnership and improved patient care. We saw minutes for quarterly multidisciplinary and Vulnerable and End of Life Patients meetings, where safeguarding issues and vulnerable patients, discussion points and actions were logged for discussion.

All staff were appropriately qualified to carry out their roles safely and effectively in line with best practice. There was a safe recruitment process and recruitment checks for staff. All new clinical members of staff had a Disclosure and Barring Service check to ensure their suitability to work with vulnerable adults. Employment files we looked at confirmed that non-clinical staff had also received Disclose and Barring checks in particular if they were to work with vulnerable adults, such as chaperoning patients during examinations. Appropriate qualification checks were carried out when new staff were recruited. Records confirmed the registration of nurses had been checked annually.

We asked staff about the practice's policy for whistle blowing. This is a process which enables staff to raise concerns identified within the practice; this included concerns of poor practice by colleagues. The staff we spoke with were aware of this process and were aware of their responsibility to raise any concerns they had. Staff we spoke with were able to describe how they supported vulnerable patients who presented as emotionally distressed or angry due to their health conditions. We asked about systems in place to keep staff and patients safe. Staff were able to show us how they would summon assistance if they felt threatened or if they were concerned for the safety of other patients or staff.

There were procedures in place at the practice for the use of staff for chaperoning. There were signs around the treatment couches to confirm chaperones were available. Chaperones were routinely offered for cervical smears. We saw there were systems in place for recording if the chaperone had been used or if the patient had declined a chaperone. However not all staff we spoke with were clear about their role as a chaperone. We discussed this with the GPs and practice manager who agreed to ensure all staff who were required to chaperone patients received updated training to ensure they were more informed about their role and the implications for protecting both the patient and the GP.

Good

Are services safe?

Medicines management

We looked at areas where medicines were stored at Ormesby and the branch dispensing surgery Hemsby. In addition we assessed arrangements for the management of medicines at the dispensary at Hemsby by observation, talking to staff and looking at records. We noted the arrangements in place for patients to order repeat prescriptions. Medicine supplies were handed to patients after prescriptions were authorised by the GPs.

Patients we spoke with told us they received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. The dispensary provided a medicine delivery service for patients who were housebound. However, we noted the dispensary had not recently monitored and assessed its own quality and performance to ensure they provided a good service to their patients.

Dispensary staffing was in line with published guidance and dispensers had attained suitable qualifications and received ongoing training and development. Members of dispensary staff received an annual competence check. The dispensary manager told us there were monthly departmental meetings to discuss issues arising including when there were medicine-related incidents. Whilst we noted there had been few dispensing errors, we could not be assured that if an error arose it would be properly raised higher within the practice. We also noted that whilst policy documents relating to medicine management and dispensing practices were updated on an annual basis and members of staff were informed of any changes, there was no written procedure for handling dispensing errors.

Medicines for use in an emergency were monitored for expiry and checked regularly for their availability. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines (the process used to maintain optimal conditions during the transport, storage and handling of vaccines), following their delivery. We checked a sample of controlled drugs (medicines controlled under the Misuse of Drugs legislation) and with the exception of a minor discrepancy found we could account for them in line with registered records.

We looked at the arrangements in place for the security of medicines at the practice. We noted that medicines including injectable medicines in clinical areas at both surgeries were not always kept securely when unattended. We noted the arrangements for the security of the dispensary at Hemsby and advised on improved security for the keys. We found that whilst prescription forms were kept securely, record-keeping practices did not allow them to be fully accounted for so we could not be assured that if blank prescriptions were lost or stolen this could be promptly identified and investigated. We discussed this with the GPs and practice manager who agreed to put improvements in place for the storage and security of medicines and blank prescriptions.

Cleanliness and infection control

During our inspection we visited patient waiting and treatment areas, office and reception areas across three of the four sites. We saw that the practices were clean and well maintained. Patients we spoke with said they were happy with the standards of hygiene at the practices.

Treatment rooms were clean and uncluttered. We found and staff told us that personal protective equipment was readily available and was in date. Hand sanitation gel was available for staff and patients throughout the practices. We observed staff using this. There were hand washing posters above wash hand basins throughout the practices including in the patients' toilets. We saw that there were body fluid spillage kits which enabled staff to clean any contamination or spillages effectively.

Infection control audits were undertaken annually across all sites by the local CCG (Clinical Commissioning Group) Infection control team, with the practice receiving high scores of between 81% at Hemsby to 94% at Martham from the last audit conducted in March 2014. The practice manager told us the practice cleaners attended the audits and along with the site nursing teams worked through any items requiring actions from the audits.

There were infection control policies in place. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. The practice employed cleaning staff to oversee daily cleaning at the practice. The practice manager told us they did a daily visual audit of the practice. The practice had undertaken regular audits of the cleaning undertaken at the practice. Areas highlighted for attention and the actions taken were recorded.

Good

Are services safe?

We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum at the practices.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example electrocardiogram machine (ECG), a machine used to record the electrical activity of the heart, spirometers (an apparatus for measuring the volume of air inspired and expired by the lungs) and blood pressure machines. We saw that the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose the typical range of conditions patients might present with. The equipment was in good order and there was evidence that it had been regularly recalibrated.

Staffing and recruitment

We looked at the staff rota and the practice appointments rota. We saw that staffing was monitored and reviewed daily by the practice and reception coordinators. However, the practice manager told us there were no formal systems in place for this. We were told by the practice manager, and staff confirmed that administrative and receptionist staff were knowledgeable of each other's roles and were therefore able to stand in for each other in times of absence or busy periods.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, professional registration checks for all clinical staff with the Nursing and Midwifery Council (NMC) or the General Medical Council (GMC). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We were told safety checks with the Disclosure and Barring Service (DBS) for all staff had been performed.

Staffing establishments (levels and skill mix) were set and reviewed to keep patients safe and meet their needs. We saw the right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and levels of staff well-being. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Staff we spoke with confirmed if they had daily concerns they would ask the practice or business manager or the reception coordinators for support and advice. Staff felt their concerns were listened to and acted on.

The practice had been accredited as an East of England Deanery training practice, as a suitable teaching centre for trainee GPs.

Monitoring safety and responding to risk

There was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities, or periodic incidents such as bad weather, changes in staffing levels and illness. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis.

We saw that staff were able to identify and respond to changing risks to patients including medical emergencies, this included responding to busy periods.

Staff told us they felt happy they could raise their concerns with the GPs or practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role. Staff described what they would do in urgent and emergency situations.

The partners held quarterly meetings to review the practice's safety record. This included a review of significant events, child protection cases and any near misses. We saw that there was a robust procedure in place to ensure that safety information was shared appropriately within the practice. Staff were informed of safety alerts and National Institute for Health and Care Excellence (NICE) guidance

Good

Are services safe?

was available on the practice shared drive. This is a system that allows staff access electronically from any computer at any of the practice locations to documents and information such as the practice policies, contact names and addresses, telephone numbers for local services, staff rotas, training information and other documents. We saw evidence that safety alerts had been disseminated and appropriate action had been taken and recorded.

There was emergency medicines and equipment available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

Staff confirmed if they had daily concerns they would speak with the GP's, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinician's in the practice and held weekly education meetings to review guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners.

There was information displayed in the reception area, in the patient leaflet and practice website regarding urgent medical treatment both during and outside of surgery hours.

Arrangements to deal with emergencies and major incidents

We saw records that all staff had received training in Basic Life Support within the last two years (for non-clinical staff) and the previous year for clinical staff. All staff asked knew the location of the Automated External Defibrillator, oxygen and nebuliser. There was a system in place to ensure emergency medicines were in date and stored correctly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included adverse weather conditions, fire and damage to the premises. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. Staff told us fire drills were regularly undertaken. Risks associated with service and staffing changes were included on the practice risk log. These included health and safety risk assessments.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice used National Institute for Health and Care Excellence (NICE) guidance to ensure the care they provided was based on latest evidence and was of the best possible quality and held weekly education meetings where these were discussed and reviewed. We saw minutes of practice meetings where new guidelines were itemised for review and discussion. All the GPs we spoke with were aware of their professional responsibility to maintain their knowledge.

We spoke with clinicians who were able to demonstrate the processes to ensure that written informed consent was obtained from patients whenever necessary. We were told that verbal consent was recorded in patient notes where appropriate and we saw evidence of this. Clinicians were aware of the requirements of the Mental Capacity Act (2005) used for adults who lacked capacity to make specific decisions. They also knew how to assess the competency of children and young people to make decisions about their own treatment.

Evidence we reviewed confirmed actions had been taken to ensure patients were given the support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs had access to online prescribing support systems. These systems ensured that the GPs were prescribing in line with national and local guidelines and that their prescribing decisions offered patients effective treatments.

Patients were referred in line with guidance and best practice to secondary and other community care services. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed by their GP according to need. We saw appropriate use of the Two Week wait referrals, (two week wait referrals are a fast track referral system for managing urgent referrals for patients with suspected cancers). We saw minutes from meetings where review of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw that care and treatment decisions were based on people's needs without unlawful discrimination. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice participated in clinical audits and peer review, which led to improvements in clinical care. Clinical audits and peer review are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. The practice manager told us audits were sometimes as a result of safety alerts or prescribing changes. We looked at records from a number of clinical audits, which had been carried out within the past year. For example we saw an audit regarding the measurement of blood sodium levels in patients on low molecular weight heparins (LMWH). LMWH are a class of anticoagulant medications used in the treatment of deep vein thrombosis, pulmonary embolisms or certain types of heart attacks or strokes. The audit was carried out to ensure there were procedures in place for patients prescribed LMWH to avoid potential adverse reactions. As a result of the audit the practice had put protocols in place to ensure patients prescribed LMWH received regular blood tests to monitor the effects of the medication.

GPs in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and NICE guidance. The staff were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used the outcome of these in their learning.

The GPs told us the practice used data collated by the NHS in order to gain an insight into the effectiveness of the practice. This included information taken from the Quality and Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of

Good

Are services effective?

(for example, treatment is effective)

quality care. The practice's overall QOF score for the clinical indicators was in line with or higher than local and national average, this showed us that the practice were providing effective assessments and treatments for patients.

We saw there were processes in place to ensure patients receiving repeat prescriptions had been reviewed by the GP. This included reviews of the latest prescribing guidance and alerts on the practice computer system for prescribing contraindications. There were also systems in place to ensure routine health checks were completed for long-term conditions such as hypertension, asthma and diabetes. The practice had put systems in place to ensure patients were reviewed in the month of their birthday. We were told this helped patients to remember when their blood test and health review was due.

The practice was participating in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess effectiveness. There were GPs assigned to each of the care homes within the practice catchment area who attended the homes for weekly rounds and were accessible for advice and support for the home when required.

Effective staffing

The practice had named GP's and nurses to act as leads for overseeing areas such as safeguarding, staffing, dispensary, unplanned admission avoidance, infection control, research, training and education.

The practice had been accredited as an East of England Deanery training practice, as a suitable teaching centre for trainee GPs. Training and development needs were identified through annual appraisal of staff performance. Staff had personal development plans; each member of staff had a personal training folder and an e-learning portfolio which was kept under review. We saw that where staff had identified training interests, arrangements had been made to provide suitable courses and opportunities. We saw that nursing staff had personal development plans and in addition to mandatory training there were four allocated study afternoons each year for staff to undertake training in areas of their specialist interest. We were told these were often attended by external speakers. We saw that staff had completed training in areas such as health and safety, equality and diversity, child and vulnerable adult safeguarding and information governance.

Records showed that GP registrars, (a GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice), nurses and health care assistants received regular clinical supervision, support and advice from the GPs and GP trainers when required. Staff we spoke with said they were supported and felt competent in their role. We spoke with a range of staff who confirmed they received annual appraisals. We looked at employment files, appraisals and training records for nine members of staff and the records we saw supported this. We saw evidence of the practice responding to staff need and managing staff performance. The practice had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice employed staff who were appropriately skilled and qualified to perform their roles. There were procedures in place to ensure checks on new staff to ensure they were suitable for a role in healthcare. We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All new staff underwent a period of induction to the practice. There were tailored staff handbooks to support new staff according to their role and job description. Support was available to all new staff to help them settle into their new role and to familiarise themselves with relevant policies, procedures and practices.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital admissions and discharges, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received by the GPs.

Good

Are services effective?

(for example, treatment is effective)

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patents. For example those patients with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses. Decisions about care planning were documented in a shared care record.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record, EMIS Web, was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice took part in the admissions avoidance scheme; vulnerable elderly patients who were most at risk of being admitted to hospital had been identified and a care plan created which identified the patient's carers, social services and community nursing team and next of kin. The care plan also included information regarding the patient's preferred place of care and resuscitation preferences to ensure the practice was able to comply with the patient's choices.

Records we saw showed us that that multidisciplinary meetings took place at the practice with a range of other health professionals in attendance to co-ordinate care and meet the needs of the patients. Palliative care meetings took place ever three months and doctors and managers from the practice met with Macmillan nurses to ensure there was a joined up approach to care and treatment for patients.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, cervical smears and minor surgical procedures. Patient's verbal consent was documented in their electronic patient notes. We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

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The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. Nurses demonstrated how they provided information, answered questions and obtained parental consent to baby immunisations. Staff were knowledgeable about the Mental Capacity Act (2005) and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

Staff we spoke with were aware of patients who needed support from nominated carers. Clinicians ensured that carers' views were listened to as appropriate. Staff were able to give us examples of how a patient's best interests were taken into account if a patient did not have capacity. Clinical staff demonstrated a clear understanding of Gillick competencies, (a nationally recognised way of assessing whether children under sixteen are mature enough to make decisions without parental consent.) There was access to a telephone translation service should patients not have English as their first language although we were told there had been little need to use this facility.

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

There was a range of health promotion leaflets available in the waiting area with information to promote good physical, mental and lifestyle health choices. We saw information about abuse, domestic violence advice and carer support displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation, alcohol consumption, contraception. Sexual health and smoking cessation sessions were provided. There were chlamydia test kits discretely available for young adults. There were also leaflets signposting patients to other local and national support and advice agencies. Information about health promotion was available on the practice website and patients were encouraged to access a local NHS supporting self-care booklet.

Information about the range of immunisation and vaccination programmes for children and adults were signposted throughout the practice and on the website. Staff we spoke with and records we viewed evidenced that the practice performed well and had a high uptake for both childhood and adult immunisation and vaccinations.

Newly registered patients were offered routine health checks with a health care assistant. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were offered a health check.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that all staff spoke with patients in a friendly, professional and helpful manner. All staff spoken with demonstrated a good understanding of how patients' privacy and confidentiality was preserved. During our inspection we overheard and observed that staff responded compassionately to patients in discomfort or emotional distress. We noted that staff approached patients in a person centred way; we saw they respected patients' individual preferences, habits, culture, faith and background.

We spoke with 14 patients and reviewed the most recent data available for the practice on patient satisfaction, including comments made by patients who completed comment cards. We looked at information from the national patient survey and a survey of patients undertaken by the practice's Patient Participation Group (a group of patients registered with a practice who have no medical training but have an interest in the services provided by the practice). The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect with 87% of those patients who responded to the survey responding that the last GP they saw or spoke with was good at giving them enough time and 85% responding the last GP they saw or spoke with was good at listening to them. The Patient Participation Group conducted a survey. The responses showed that patients were happy with how all staff including doctors, receptionists and nurses responded to their needs. Patients indicated that they were listened to and treated with compassion and dignity.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 20 completed cards, all were positive about the service they experienced. Patients said they felt the practice provided excellent care and treatment. Patients commented that staff were kind, efficient, helpful and caring. They said staff were respectful and treated them with dignity

We saw that staff were careful to follow the practice confidentiality policy when discussing patients' treatment in order that confidential information was kept private. This was respected at all times when staff were delivering care, in staff discussions with people and those close to them, and telephone conversations and in written records. Facilities were available for patients to speak confidentially to clinical and non-clinical staff.

The practice had a range of anti-discrimination policies and procedures and staff told us 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 practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There were systems in place to support patients and those close to them to receive emotional support from suitably trained staff when required (particularly near the end of a person's life and during bereavement). Bereaved family members were offered the opportunity to speak with the GP or nurse whenever they wanted. Information was available for patients for bereavement support patients we spoke with told us they felt supported by the practice. A record of patients who had recently died was in place to ensure that inappropriate correspondence was not sent.

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 involved in decision making about their care and treatment. Patients told us they felt listened to and supported by staff and were given sufficient time during consultations to make informed decisions about the choice of treatment they wished to receive. Patient survey information and completed comment cards we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas.

The clinical staff we spoke with told us that they provided information to support patients to make decisions about their care and treatment. This included giving patients the time they needed to ensure they understood the care and treatment they required. The patients we spoke with and the comments cards we received confirmed this and patients told us that their views were listened to. Staff told

Good

Are services caring?

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

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Patients experiencing poor mental health received treatment, care and support at the practice and in the community when they needed it. The practice held a register of its patients known to have poor mental health and had effective procedures to invite patients to attend an annual health review. The practice worked in conjunction with the local mental health team and the community psychiatric nurses.

The practice recognised that some vulnerable patients may find it difficult to attend the practice for care and support. The practice offered telephone consultations for patients that found it difficult for whatever reason to attend the surgery.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice worked collaboratively with other agencies such as district nurses, social services, community mental health teams, alcohol and substance misuse services and regularly shared information (such as special patient notes) to ensure efficient and timely communication of changes in patients care and treatment.

We saw that the practice monitored individual clinical capacity and this ensured they were able to meet patient needs. Appointment times were flexible to meet the needs of patients from the different population groups. GP appointments were available up to 8pm two evenings a week to help serve working aged patients. Home visits with GP's and nurses were available where patients were unable to attend appointments at the practice. The practice operated a duty doctor system and telephone consultations were available each day. Same day emergency appointments were available. Internet access was available for patients who may need to book appointments and request their prescriptions on-line.

The practice provided care to local care homes. The practice worked closely with the staff at the homes to ensure continuity of care. GPs visited the homes on specific days for any routine issues. However, we were told, should patients need additional medical input during the week, the GP would attend for home visits.

Nurses and GP's contributed to the early detection of conditions through the health assessment and screening checks provided by the practice nurses. Patients we spoke with told us they were advised of their test results promptly and we were told the GPs discussed the results with them if further treatment was required. The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients' and their families' care and support needs. Patients who were carers were offered support through the carer's support group.

The practice had systems in place to seek and act on feedback from patients. There was a suggestions and comments box available for patient's feedback in the waiting room areas. The practice had an active patient participation group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. The practice had appointed a PPG chairperson and secretary who had introduced links to the younger practice patient population through local schools. There was evidence of quarterly meetings with the PPG throughout the year.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice was accessible for any vulnerable group and operated an open list so that patients who were temporarily resident in the area could register as a temporary resident. The staff culture evidenced that patients could access the practice's services without fear of prejudice.

The practice had identified patients with learning disabilities. These patients had individual care plans. People with learning disabilities were offered appointments that suited their working hours.

Staff were prepared to assist patients with hearing and visual impairment, or whose first language was not English accessing healthcare where necessary.

The practice offered telephone consultations for patients that found it difficult for whatever reason to attend the surgery.

The practice had an equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

The practice was easily accessible to patients with mobility issues. Corridors leading to consulting and treatment rooms were suitable for wheelchair access. There were accessible toilets and baby changing facilities. There were hearing loop facilities for patients who were hearing impaired. The practice had dispensing services at two of the branch practices and patients could obtain their prescribed medicines at these sites. The practice had recognised that some patients may have difficulties obtaining repeat prescriptions and medicines and there were arrangements for home delivery of medicines for patients who were housebound.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

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 through the website. Appointments were available to book in advance, book on the day and to book as online appointments. Appointment times were from 8am to 1pm Tuesday and Wednesday, 8am to 5.30pm Monday, Thursday and Friday with extended hours appointments until 8pm Thursday and Tuesday at the Hemsby branch surgery. Appointments were available at the branch surgeries when the main practice was closed on Tuesday and Wednesday afternoons.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. Patients could access, change or cancel booked appointments via the practice website or the telephone booking system. Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Services were adapted to meet the needs of patients with disabilities. The practice was situated on the ground floor; the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities

The majority of the practice population were English speaking patients. There were arrangements for supporting patients whose first language was not English.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice and these were discussed at the weekly education meetings.

There was a complaints procedure which patients were informed of by the practice website and in the practice leaflet. Staff told us that if someone wanted to make a complaint, the receptionist would see if there was anything they could help with, or they would refer patients to speak with or see the practice manager. Staff we spoke with were aware of the complaints policy and told us they would direct any complaints to the practice manager. Patients we spoke with told us they had not needed to complain, but were aware how to. We were told they felt the practice would listen to their concerns.

We saw the practice's log and annual review of all complaints received. The review recorded the outcome of each complaint and identified where learning from the event had been shared with staff. However we noted that there were incidents where complaints would have been better reviewed as a significant event. For example where concerns had been raised regarding a missed diagnosis. We discussed this with the GPs and the practice manager. We were told the practice would undertake a thorough and on-going review of complaints handling and procedures following the inspection to establish where significant events had taken place. We were told where appropriate these would be dealt with through the significant event procedure alongside the complaints procedure.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care general practice delivered via small primary care teams. It was evident that senior staff had continued to search for further areas of improvement on an on-going basis. For example, we were told the practice monitored appointment availability on a daily basis to ensure it was adequate in meeting patients' needs There were plans to develop the practice building to include a video conferencing suite to enable conferencing across each site and maximise GP time. The results of the Patient Participation Group (PPG) patient survey had highlighted that few patients were aware of the on-line facilities to book appointments and request repeat prescriptions on-line. The practice PPG members had put action in place to inform patients of this facility. For example, messages had been added to prescriptions and information placed in the local parish newsletters.

We spoke with 22 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff felt they were encouraged to make suggestions that led to improved systems and patient care.

Governance arrangements

There were systems in place to monitor all aspects of the practice. This included risk assessments, clinical audits, infection control, safeguarding and complaints. There were practice leads responsible for all areas within the practice and staff were aware of each other's responsibilities and who they could report to should they have any concerns. There were a range of audits and checks carried out to ensure patients were treated in safe and appropriate premises and that they received safe and high quality care and treatments.

The practice and business manager took an active role in overseeing and reviewing the protocols, policies and systems in place across the practice and the branch sites, to ensure they were effective and consistent. A GP partner oversaw staff training and education to ensure staff received the training appropriate for their role.

There was a clinical governance GP lead and a variety of regular meetings were held between the GPs and the practice and business manager. During these meetings decisions about clinical issues were discussed and any outstanding issues were reviewed and where appropriate resolved. We saw that the arrangements for patient appointments were regularly discussed to see if these could be improved. Other regular staff meetings were held where the day to day business of the practice such as clinical issues, new initiatives, finance, staff training issues and skill mix were discussed. We saw the minutes from meetings where decisions had been made. Any actions arising from these meetings were clearly documented, allocated to staff for completion, and followed up at subsequent meetings. We were shown the practice 'shared drive'. This is a system that allows staff access electronically from any computer at any of the practice locations to documents and information such as the practice policies, contact names and addresses, telephone numbers for local services, staff rotas, training information and other documents. For example clinical guidelines and referral forms. Staff showed us how they could easily access this information from any computer location within the practice. The systems we saw and feedback from staff evidenced a strong governance structure in place within the practice.

Leadership, openness and transparency

The practice held a variety of regular practice meetings. These included a review of practice learning points or significant events, training requirements and audits. Actions taken and lessons learned from these were discussed and recorded. There were on-going checks of the safe running of the practice such as fire safety, infection control monitoring and testing of equipment and utilities, for example servicing of the boiler.

The GPs and management staff were aware of the needs of the practice population and tailored the service to meet the needs of the local population groups. The clinical team had lead areas of responsibility as did each member of staff such as the practice nurses who led on infection prevention control and diabetes services. All staff worked closely and effectively together to ensure patients received timely and appropriate care.

We found there was daily monitoring of the patient appointment system to ensure the system was accessible and responsive to patient needs. Patients who repeatedly failed to attend appointments were identified and written to advising them of the importance of attending appointments.

Are services well-led?

Good

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

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

The practice had an active Patient Participation Group (PPG). The PPG is a forum made up of patient representatives and staff who discuss changes within the practice and how services could be improved for patients. There was information on the practice website informing patients about the group and how to join. We spoke with representatives of the practice PPG during the inspection. We were told they felt the practice was supportive and had a good working relationship with the PPG. The PPG had recently approached local schools to encourage involvement from the younger patient population.

The PPG conducted annual patient surveys. The results from the most recent survey, which was carried out in February 2014 showed that the majority of patients were happy with the care and treatments that they received and how they were treated by staff. The less positive comments received related to difficulties in making appointments, lack of awareness with regard to on-line services available at the practice, recruiting younger members to the group and further involvement and feedback for the PPG members. These comments were reviewed by the practice team and action plans had been put in place. These included members of the PPG approached local schools and youth groups to promote interest among the younger patients' population, posters and information detailing on-line services were in the practice and on the practice website.

Patients we spoke with told us that they were aware of the patient group. Those who were unable to be part of this group told us that they were always listened to by staff at the practice. Members of the patient group said that they were able to help inform and shape the management of the practice in relation to patient priorities, planned practice changes and the outcomes from local and national GP surveys.

Staff were aware of how to raise suggestions and concerns. The practice had a whistle blowing policy which was available to all staff in the staff handbook. Staff told us they felt confident they could raise a concern and felt there comments would be listened to. We were told by staff that they were encouraged to attend and participate in staff meetings.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed they received annual appraisals where their learning and development needs were identified and planned for.

The practice referred to significant events as practice learning points and encouraged all staff to complete a practice learning point form for any untoward event. We saw that there were arrangements for learning from incidents, significant events (practice learning points) and complaints. However we noted that there were incidents where complaints would have been better reviewed as a learning point or significant event. Following discussion with the practice GPs and management team we were told these would in future be reviewed in conjunction with the significant event procedure (practice learning points procedure) and the practice complaints procedure.

Care and treatment provision was based upon relevant national guidance, the practice told us referrals were regularly discussed between clinicians and were available on the practice shared drive. Learning points were itemised for discussion on weekly education meeting agendas.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Completed audit cycles showed that changes had been made to improve the quality of the service, to ensure that patients received safe care and treatment.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

We saw evidence that learning from significant events (practice learning points) took place. There were systems in place to audit and review significant events. These audits resulted in action plans and implementation of changes to improve patient safety, care and practice performance.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at nine staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very

Are services well-led?

Good

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

supportive of training. The practice was designated a training practice where GP registrars (trainee GPs) were offered placements to develop their skills and clinical competences.