

# The Homewell.Curlew Practice

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Homewell.Curlew practice on 2nd July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. The practice is also rated as good for the six population groups which 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 and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice had recently merged and involved patient groups to minimise disruption to care.

- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

**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?

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. Lessons were learned and communicated widely to support improvement.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Good



# Summary of findings

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

## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

The practice had policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

**Good**



# 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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

Patients over 75 have a named GP and are invited to have a health check when they reach their 75th birthday. The GP would screen the patient's notes and decide what, if any, blood tests or other tests may be required.

The practice had a telephone hub that was staffed by a Nurse Practitioner or GP during the day. This provided direct contact with a clinician throughout the day.

Older patients were encouraged to see their regular GP and the reception staff and clinicians in the hub assisted with booking appointments appropriately. This included organising preliminary tests prior to appointments.

For example: if an elderly person called up with a new onset of shortness of breath then an ECG and full set of observations would be recorded by the health care assistant (HCA) prior to seeing the GP that day, or it may be at the time of booking staff notice that some blood tests are outstanding the practice would fit them in with the HCA on the same day they were attending to see the GP to ease the difficulty of accessing other services for this group

For urgent care, patients were seen on the day either at the practice or at home. The practice had a register of patients who were unable to attend the practice.

The practice had recently invested in a visiting GP service. A GP would start visiting patients at their home in the morning as visit requests are coming in. This has helped patients receive care sooner than previously and sometimes helped prevent hospital admissions by having more time in the day to organise care via other agencies. This in turn has provided GPs with protective time at lunchtimes when they traditionally would have visited. They can use the time to organise referrals, plan care, prescriptions, attend meetings.

Seasonal Influenza, Pneumococcal and Shingles vaccination clinics were arranged and the practice visited patients at home if required to vaccinate.

Good



### People with long term conditions

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

Good



# Summary of findings

The practice maintained a Case Management Register (CMR) for patients with complex needs or those at high risk of admission.

Patients on this register had care plans and direct line access to the practice. Meetings were held monthly to discuss care for these patients within the multidisciplinary team (MDT).

The practice also maintained a gold standards framework (GSF) register for palliative care patients and monthly MDT meetings with the integrated care team and external organisations.

The practice maintained a register of people with long term conditions. Patients on this register were invited to attend annual clinics for reviews.

One GP has a special interest in these clinics and supported the Nurse Practitioners with weekly clinical case review meetings.

Patient care was planned according to individual needs. Care was based according to local and NICE guidelines.

The practice participated in a local incentive service for supporting patients with diabetes.

The telephone hub clinician helped identify when patients with long term conditions needed urgent access and provided them with an on the day appointment if required.

Patients with long term conditions had direct telephone access to the practice and urgent care was arranged to try and avoid hospital admissions.

## Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises was suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice offered shared antenatal care and offered post-natal visits.

The practice provided baby vaccination clinics and offered an invite and recall system for those clinics and had processes in place for chasing non-attenders to improve uptake figures.

Good



# Summary of findings

Safeguarding procedures were in place and there was a lead safeguarding GP. This GP co-ordinated the care of vulnerable families with external agencies and also at the practice and advised on any safeguarding issues for colleagues.

There was open clinical access to young families via the telephone hub system to ensure same day access was provided when needed.

## **Working age people (including those recently retired and students)**

The practice is rated as good for the care of working-age people (including those recently retired and students).

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice was part of the extended hour's scheme. A recent patient survey showed patients preferred early morning or late evening appointments and the practice changed its times to accommodate this.

Online appointment booking and prescribing services were available.

Electronic prescription service was in place to help reduce the need for workers to attend the practice for their prescription.

Telephone consultations were available for patients if they were unable to attend the practice.

**Good**



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

There was an open access policy for patients who were vulnerable and the practice signposted or booked them in to the most appropriate health care professional or external agency.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**Good**



# Summary of findings

The practice had links with local voluntary services via the local church and used this service to refer patients to food banks and other help.

## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice had a register for patients experiencing poor mental health (including those with dementia). These patients were invited into the practice for an annual health check.

The practice has taken part in a research study with University College London to offer patients with severe mental health problems help to manage cardiovascular risk.

The Patient Participation Group was currently working to develop the practice into a dementia friendly practice. They had identified local agencies for support and dementia friendly places to visit including a local café.

**Good**



# Summary of findings

## What people who use the service say

We spoke with three patients on the day of our inspection. All of them were very positive about their experiences of care and treatment at the practice.

All the patients we spoke with told us that their treatment was clearly explained to them and they were able to ask questions and make choices about their treatment or medicine. Patients said they felt there were enough staff and the staff had the right skills and experience to meet their needs.

They also told us they had enough time with the GP or nurse to discuss their concerns.

We received two comment cards on the day of our inspection. All the comments told us that the practice was caring and compassionate.

We reviewed data from the national patient survey which showed the practice was rated above the national average by patients who were asked if they were given enough time during their appointment by clinicians.

Only 71% of patients found it easy to get through to the practice by phone compared to the CCG average of 84%. The practice has responded by introducing a new telephone hub and triage system and has plans in place to further improve the telephone system.

# The Homewell.Curlew Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

## Background to The Homewell.Curlew Practice

The Homewell.Curlew Practice is a large practice serving the health needs of approximately 15,500 patients.

The practice team consists of nine GP partners and two salaried GPs who together work an equivalent of six and a half full time staff. Supporting the GPs are one Nurse who is also a partner in the practice, three nurse practitioners, two practice nurses and five health care assistants.

The practice is a registered teaching practice with two GP trainers. This means that GP Registrars are placed at the practice as part of their training and supervision before becoming fully qualified GP's. The practice is currently training two registrars. Medical students from Southampton University also receive training at the practice.

GPs and nursing staff are supported by an administration and reception team including a business manager and two practice managers.

The Homewell Practice recently completed a merger with The Curlew Practice in April 2015 and became known as The Homewell.Curlew Practice. This has seen an increase of nearly 4,000 patients using the practice.

The practice is located at

Havant Health Centre, Civic Centre Road, Havant, PO9 2AQ

The opening hours are Monday to Friday 8am to 630pm. Extended hours opening is from 730am to 8am Monday to Friday and from 630pm to 7pm Monday to Thursday.

Outside of these hours, medical advice and treatment is provided by Hampshire Doctors On Call. This is staffed by local General Practitioners. Patients can also call NHS 111.

There is a recorded answerphone message telling patients the out of hours emergency numbers to ring. There is a minor injuries walk in centre at St Mary's Hospital. The nearest Accident & Emergency Department is at Queen Alexandra Hospital, Cosham.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with five patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice before and during our visit.

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 include:

- 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)

# Are services safe?

## Our findings

### Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw an example where discharge summaries from hospital were not clear about the medication for patients. The practice investigated and dealt with these in a timely manner.

We reviewed safety records and incident reports from the previous 12 months and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of eight significant events that had occurred during the previous 12 months and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held every two months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the patient safety champion. They showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared amongst staff. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again. We saw one example where a new patient had been given a different

medicine to their usual one because it had a similar sounding name. The practice has since introduced improved methods of checking new patients existing medicines to prevent this happening again.

National patient safety alerts were disseminated verbally and electronically to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at monthly meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. 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. Contact details were easily accessible.

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to level 3 to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or patients with learning disabilities. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy that had been reviewed in the previous 12 months. This was visible on the waiting room noticeboard and in consulting rooms and on the

## Are services safe?

practice web site. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

All patients are verbally offered a chaperone for any intimate examination. If the use of a chaperone is declined that this is recorded on the computer notes for the patient. The staff we spoke with explained there are plans to train reception staff to be chaperones if they wish and DBS will be completed so they can fulfil this role. Male chaperones are also available.

The practice had reviewed its information governance policy in March 2015 and all staff had received up to date training on data protection. We saw the practice was registered with the information commissioners office. This means the practice will abide by the data protection act to keep patients personal data and information, including records, safe and secure. All data was securely stored and only accessed by those authorised to do so. Cleaning staff who had access to the records room had signed confidentiality agreements. The practice had a named lead for data protection.

### Medicines management

We checked medicines stored in medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out to ensure medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription

forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in September 2014. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under the PGD.

Patients had access to the electronic prescription service. Patients were able to get their repeat prescriptions sent to a pharmacy of their choice and this meant they did not have to attend the practice to collect them.

### Cleanliness and infection control

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

An infection control policy and supporting procedures had been reviewed in July 2015 and were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Bodily fluid spill kits were available for staff to use if needed.

## Are services safe?

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

A clinical waste policy had been reviewed in June 2015 and staff we spoke with were aware of the importance of handling all clinical waste in a safe way. Clinical waste bins were kept locked and secured and the practice had a contract for the removal of clinical waste. Consignment notes for this were kept in accordance with the waste regulations.

The practice confirmed the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings) was carried out and we saw a water hygiene risk assessment, a practice risk assessment and evidence twice weekly water flushing. It was also made clear that NHS property services is responsible for the building.

### 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 took place. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was November 2014. A schedule of testing was in place and we saw evidence that calibration of relevant equipment including weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer had taken place in February 2015.

### Staffing and recruitment

The practice had a recruitment policy, reviewed in May 2015, that set out the standards it followed when recruiting

clinical and non-clinical staff. We looked at four recruitment records and they all contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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 told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

### 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw that the reception staff rota was produced one month in advance and any gaps or hot spots identified were filled by relief staff. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

# Are services safe?

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in the previous 12 months. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A comprehensive 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 power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in June 2015.

NHS property services were responsible for the testing and servicing of the fire alarm system. The fire extinguishers we checked had been tested in April 2015. Records showed that staff were up to date with fire training. All the fire exits were clearly signposted and illuminated where necessary.

# 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. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, dementia and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in

reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us five clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Other examples included audits in referral rates, diabetes, clinical outcomes and cancer care.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This

# Are services effective?

## (for example, treatment is effective)

practice was not an outlier for any QOF (or other national) clinical targets. It achieved 96.5% of the total QOF target in 2014, which was above the national average of 93%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better when compared to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- The dementia diagnosis rate was comparable to the national average

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar compared with national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss and plan the care and support needs of patients and their families. Once the care needs have been agreed the care is coordinated amongst the teams and the computer records are updated accordingly.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as those patients

with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions including diabetes and heart failure. We were shown data that these patients had all received an annual review.

### Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with all of them having areas of specialist interest. 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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All of the GPs have an annual appraisal.

All of the nursing staff, including health care assistants, had signed up to the new nursing appraisal system through the local medical committee (LMC).

Records showed that all staff had received an annual appraisal with the previous year that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training.

Doctors who were training to be qualified as GPs offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. The practice took pride in being a training practice and clearly identified to patients they may be seen by a registrar. We spoke with three patients who told us they did not mind seeing a registrar at all.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and running specialist clinics such as asthma. Those with extended roles in seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were able to demonstrate they had appropriate training to fulfil these roles.

# Are services effective?

(for example, treatment is effective)

## Working with colleagues and other services

The practice worked with other service providers to meet patient's 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 practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was one incident identified within the last year of a discharge that was not followed up due to the practice not receiving the discharge letter. This was raised and investigated as a significant event with appropriate action taken.

Emergency hospital admission rates for the practice were 17.6 per 1,000 compared to the national average of 14.4 per 1,000 people.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those 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 and an oncology team and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

## Information sharing

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

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

Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

## Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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

# Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions, for example, joint injections. Verbal consent, for intimate examinations for example, was documented in the electronic patient notes with a record of the discussion and whether a chaperone was used.

## Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic screening and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 100% of patients in this age group were offered the health check. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice took a holistic approach to patient care. The GPs explained the offered advice at consultations with regards to smoking, drinking, weight loss and overall health and wellbeing. They took the opportunity of a consultation to offer opportunistic health screening. These included well man and well woman clinics.

The practice's performance for the cervical screening programme was 94%, which was above the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 57.5%, and at risk groups 68%. These were similar to the national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 93.5% to 97.5% and five year olds from 92.4% to 100%. These were comparable to the CCG averages.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 124 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

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

- 87% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 94% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%

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

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in another room which helped keep patient information private. A quiet room was available at the reception for those patients who wished to discuss concerns in private.

The reception was large and there was a high wall separating the staff from patients. The practice explained that they had plans to redesign the reception area to better suit patients needs but were restricted as the building was controlled by NHS property services. We saw evidence showing us the practice was trying to seek approval for a new design. The practice had encouraged patients to queue further away from the reception desk to better protect privacy.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown three examples of reports on recent incidents that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

### Care planning and involvement in decisions about care and treatment

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

## Are services caring?

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice also used sign language services in order to communicate with some of their patients.

All of the staff working at the practice had completed training in equality and diversity.

### **Patient/carer support to cope emotionally with care and treatment**

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

- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.

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

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice implemented and followed the gold standards framework for end of life care. Monthly multidisciplinary meetings, including district nurses, the palliative care nurse and care co-ordinators took place. Each GP took responsibility for patients receiving end of life care. This was to ensure continuity of care and support for the patient and their relatives.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. This included the use of language telephone lines and longer appointments for those with long term conditions.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A survey was conducted amongst the patients with regards to extended hours opening. As a result of this 66% of patients who responded stated they preferred weekday evening appointments to weekend opening and the practice changed it's appointment times as a result. There are still weekend appointments available.

### Tackling inequity and promoting equality

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

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

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

There were male and female GPs and nurses in the practice; therefore patients could choose to see a male or female GP or nurse.

The practice provided equality and diversity training and all staff were recorded as having attended this. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team meetings. One example of this was making the reception desk more accessible to patients who used wheelchairs.

### Access to the service

The opening hours are Monday to Friday 8am to 630pm. Extended hours opening is from 730am to 8am Monday to Friday and from 630pm to 7pm Monday to Thursday. Extended hours appointments were primarily for patients who were unable to make normal surgery times, either because they work out of the area or because of other commitments, and could be booked a maximum of a week ahead to minimise missed appointments.

The practice also operates a same day service. This same day service is a nurse practitioner led clinic. It was suitable for urgent or minor illness, such as chest or abdominal pain, new backache, eye infections, coughs, colds, asthma or chest infections, diarrhoea and vomiting, earache, minor injuries, rashes and sinus problems. Patients were triaged by a nurse practitioner for the most appropriate appointment for their needs. Urgent telephone advice was also available throughout the day.

The practice had created a telephone hub that was used to answer all calls to the practice. It was also staffed by a trained clinician to help triage urgent phone calls and provide medical advice.

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 and cancel appointments through the website.

# Are services responsive to people's needs?

(for example, to feedback?)

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

Medical advice and treatment out of hours was provided by Hampshire Doctors On Call. This was staffed by local GPs, including some of those from the Homewell.Curlew practice. Patients were also able to call NHS 111 for advice.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

The last patient survey information we reviewed showed patients had not responded positively to questions about access to appointments and generally rated the practice below the national average in these areas. For example:

- 68% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%. However, the practice has since changed its appointment times following a specific survey about this and has put in plans to survey patients about this again.
- 64% described their experience of making an appointment as good compared to the CCG average of 81% and national average of 73%. The practice explained their patient list had gone up 33% from 12,000 to nearly 16,000 following the recent merger and this accounted for the poor result in this area.
- 51% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 59% and national average of 58%. However, 94% said the GP always gave them enough time.
- 71% said they could get through easily to the practice by phone compared to the CCG average of 84% and national average of 73%. The practice have implemented a new telephone triage system and have put in plans to carry out another patient survey as the patient participation group stated the 2014 survey results did not reflect the improvements the practice had made.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor or nurse on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment been able to make appointments on the same day of contacting the practice.

There was level access to the building. The surgery had wide doors to allow for wheelchair access and there was good access to all of the consultation rooms. Accessible toilets were available throughout the building. The practice had access to interpreters, language telephone lines and signers to assist those who used sign language.

## Listening and learning from concerns and complaints

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

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

We looked at five complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way with openness and transparency in dealing with the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. This included zero tolerance towards abuse posters displayed at reception.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found the vision and practice charter were part of the practice's strategy and business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included giving patients same day emergency appointments, and to promote good health and avoid illness.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The Homewell practice had completed a merger with the Curlew practice less than two months prior to our inspection in April 2015. There was agreement with the patient groups, GPs and staff that the merger was the right thing to do. Patients of both practices were kept informed of the merger through the web site, information leaflets and by speaking with staff. The patient participation group were involved throughout the merger.

GPs we spoke with told us patients would benefit from the merger as there would be better access to care, including palliative care and also the same day clinic. They also explained there was improved working amongst the GPs and a better work life balance.

The practice had identified areas for improvement. These included methods to reduced patient waiting times, creating a patient hub, further improving the telephone system and redesigning the reception area.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at seven of these policies and procedures and all of them had been reviewed annually and were up to date. One example was the clinical governance policy that had been reviewed in June 2015.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a

lead nurse for infection control and there was a lead for safeguarding. We spoke with six 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 concerns.

The CCG had developed a local commissioned service aimed at clinical governance in general practice. The aim of the scheme is to provide enhanced training and learning to help further identify and prevent avoidable harm and improve the patient experience. The practice has a named lead for this role.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example diabetes and antibiotics audits were undertaken and improvements in these areas had been made when audited again. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. One example of this was a plan to introduce a new telephone system following on from the patient survey.

Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example there was a detailed risk register for each room in the practice. The practice monitored these risks on a weekly basis to identify any areas that needed addressing.

The practice held weekly meetings where governance issues were discussed. We looked at minutes from these

# Are services well-led?

Good 

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

meetings and found that performance, quality and risks had been discussed. Partners met every lunchtime and there was a full partners meeting every two months. Practice meetings were held monthly.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example equality and diversity and recruitment. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy, that had been reviewed in March 2015 and was available to all staff. Policies were available electronically on any computer within the practice.

## Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen. All of the staff we spoke with told us they were involved in discussions about how the practice and were encouraged to identify ways to improve the service delivered.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they felt confident in raising any issues. They told us they felt supported and were respected and valued by the partners and their colleagues in the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG. The PPG met every quarter but explained they were aiming to meet on a monthly basis. The PPG told us the practice acted on feedback they provided and this was evident in the change of opening hours and the introduction of new telephone systems.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. They explained that a new patient survey needed to be carried out as the practice had merged since the date of the last survey. They said the practice had made improvements since the merger and the last survey did not reflect the current good practice.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

## Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had educational meetings where trainers attended.

The practice was a GP training and research practice.

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