Dr BN Macdonald & Partners

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

Contents

Summary of this inspection

Page

Overall summary 2
The five questions we ask and what we found 4
The six population groups and what we found 6
What people who use the service say 9
Areas for improvement 9
Outstanding practice 9

Detailed findings from this inspection

Our inspection team 10
Background to Dr BN Macdonald & Partners 10
Why we carried out this inspection 10
How we carried out this inspection 10
Detailed findings 12

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr BN Macdonald & Partners practice at Barrington Road, Altrincham Cheshire.

We carried out a comprehensive inspection on 19 January 2015. We spoke with patients, members of the patient participation group and staff, including the management team.

The practice was rated as good overall. A safe, caring, effective, responsive and well-led service was provided that met the needs of the population it served.

Our key findings were as follows:

- All staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were maximised to support improvement.
- Feedback from patients was positive.
- The practice were using proactive methods to improve patient outcomes We found an open culture and evidence that staff were motivated and inspired to provide kind and compassionate care.
- The practice had a clear vision which had quality and safety as top priorities. This vision was owned by all the practice staff with evidence of team working across all roles. The leadership culture was open and transparent. We found high levels of staff satisfaction. 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.
- Patients told us they are treated with compassion, dignity and respect and they are involved in care and treatment decisions.
- The practice implemented suggestions for improvements and makes changes to the way it delivers services as a consequence of feedback directly from patients and from the Patient Participation Group (PPG).

We saw several areas of outstanding practice including:

Summary of findings

- Recall systems for long term conditions were effectively managed in a timely manner by dedicated staff to ensure appropriate management of patient's conditions. Staff could demonstrate they had recalled all patients with long term conditions for their annual reviews.
- Care of patients with long term conditions was patient focussed and fully responsive to their needs with individual care plans implemented to ensure their needs were fully met at a time when they most required it. This had led to a reduced attendance at A&E in a small group of patients who were vulnerable due to their long term conditions.
- We were given numerous examples of the practice responding to feedback from their Patient Participation Group and taking action to improve the service. These included supplying distraction equipment such as MP3 players for anxious patients prior to minor surgery.

In addition the provider should:

- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Ensure safeguarding flags are evident on all relevant patient records when records are opened.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risk management was comprehensive and well managed. There were sufficient staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Clinical Commissioning Group (CCG) data showed patient outcomes were at or above average for the locality. National Institute of Health and Care Excellence (NICE) guidance was referenced and used routinely. The practice had links to neighbouring practices to share best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned. The practice carried out appraisals and formulated personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from patient surveys showed patients rated the practice higher than other practices for several aspects of care. Patients said they were treated with compassion, dignity and respect. They were involved in planning for their care and treatment. We observed a patient centred culture and found strong evidence staff were motivated and inspired to offer kind and compassionate care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and the practice promoted patients accessing a named GP for continuity of care where possible. Urgent same day appointments were available everyday with either a nurse of GP as required. The practice had appropriate facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues

Summary of findings

raised. There was evidence of shared learning from complaints with staff. Staff were able to discuss with us where responsive care plans had been put in place to support patients with their immediate health needs which had reduced attendance at A&E for particular patients.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements were proactively reviewed. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and acted upon it where possible.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Patients at risk of an unplanned hospital admission had a care plan in place. Nationally reported data showed that 25.7% of the patient population were aged 65 or above this was in line with the national average. The practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, avoidance of unplanned admissions to hospital (patients at risk of an unplanned hospital admission had a care plan in place), support for people with dementia, Flu vaccination programmes and a shingles vaccination programme for those aged 70 and above. The practice was responsive to the needs of older people including offering home visits as required.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There was a high prevalence (52.7%) of patients with long standing conditions, such as cardiovascular disease, Chronic Obstructive Pulmonary Disease (COPD) and diabetes amongst the patient population. There were named GP leads for each area. Nursing staff had additional training and qualification which enabled them to focus upon specific chronic conditions and appropriately assist in the management of them through a comprehensive schedule of clinics. These patients were recalled using an effective administrative system which ensured they had structured annual reviews to check their health and medication needs were being met. For those with the most complex needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice offered enhanced services to meet the needs of patients with long-term conditions such as avoidance of unplanned admissions to hospital through care planning.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following up children who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation clinics for babies and young children were available on a weekly basis. A range of enhanced services were available such as whooping cough in pregnant women, hepatitis B for new born

Summary of findings

babies, Measles Mumps and Rubella (MMR) vaccination for young people and contraception services. Appointments were available outside school hours and the premises were suitable for children and babies. Children and young people were treated in an age appropriate way and recognised as individuals.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible. Patients were able to book appointments in extended opening hours on Wednesday and Thursday evenings until 1940. A full range of health promotion and screening which reflects the needs for this age group was available.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with learning disabilities. The practice had a residential facility for people with learning disabilities within their practice area and supported patients living here. Patients with learning disabilities were offered annual health checks, longer appointment were available if required and recall letters were in pictorial format to aid understanding.

The practice worked with multidisciplinary teams in the case management of vulnerable patients. Staff knew how to recognise the 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.

Patients with conditions which led them to be vulnerable at times of crisis had care plans in place to assists them to be treated in an appropriate setting at a time which addressed their immediate need without the need for assistance from the ambulance service or admissions to A&E. This had led to this group of patients reducing their attendance at A&E and supported a timely management of their immediate condition by staff who were familiar with their circumstances and needs.

People experiencing poor mental health (including people with dementia)

Good

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

within this group received a timely recall for their annual physical health check. The practice worked with multidisciplinary teams in the case management of people experiencing poor mental health. The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia which they were actively working to improve upon. Staff told us the practice had sign-posted patients experiencing poor mental health to various support groups, and they were proactive in helping patients address issues to improve all aspects of their health

Summary of findings

What people who use the service say

We received 22 completed Care Quality Commission (CQC) comment cards which included feedback from male and female patients across a broad age range. Patients spoke positively about the practice, and the care and treatment they received. Their descriptions of staff included helpful, friendly, thorough and kind. Patients told us staff understood and they were treated with dignity, compassion and respect. They told us staff listened to them and took time to discuss and explain treatment options. Patients felt involved in planning their care and treatment.

All patients expressed satisfaction about the ease with which they could get an appointment. They told us urgent appointments were always available and they were sure they would be 'slotted in' even if all appointments were taken should they need it.

Three patients told us they thought some flu clinics being held at weekend, where they were given refreshments was an excellent idea to encourage people to come for the immunisations it made it a social occasion.

We spoke with the chair of the patient participation group (PPG) who had assisted at the flu clinics with serving refreshments. They told us they had used this as an opportunity to promote the PPG and try to recruit new members.

Several patients commented on the environment. They told us it was always safe and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Ensure safeguarding flags are evident on all relevant patient records when you open the record.

Outstanding practice

- Recall systems for long term conditions were effectively managed in a timely manner by dedicated staff to ensure appropriate management of patient's conditions. Staff could demonstrate they had recalled all patients with long term conditions for their annual reviews.
- Care of patients with long term conditions was patient focussed and fully responsive to their needs with individual care plans implemented to ensure their needs were fully met at a time when they most required it. This had led to a reduction in a group of patient's attendance at A&E.
- We were given numerous examples of the practice responding to feedback from their Patient Participation Group and taking action to improve the service. These included supplying distraction equipment such as MP3 players for anxious patients prior to minor surgery.

Dr BN Macdonald & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspector. The team included a GP and a specialist advisor.

Background to Dr BN Macdonald & Partners

Dr BN Macdonald & Partners practice is situated on a busy main road near the centre of Altrincham. There are currently 7079 patients registered with the practice

The patient population groups are in line with national averages however the 0-4 years population group is above this. This practice has an annual turnover of patients or 7.96% but the practice was able to articulate this figure was higher than in previous years due to accepting patients from a local practice which had closed and these patients moving on again to a practice nearer their home. Information published by Public Health England rates the level of deprivation within the practice population group as nine on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice team comprises of five GPs including three females and three practice nurses working a variety of hours. The practice manager is supported by a team of reception and administrative staff. The practice has a virtual patient participation group with 10 active members.

Opening hours are 8.30am to 6.00pm on Mondays, Wednesday and Friday, and 8.30am to 7.40pm Wednesday and Thursday. Surgeries are available mornings, afternoons and evenings. When the practice is closed an out of hours service, Medicall, meets the care and treatment needs of patients.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

- 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 visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew. We spoke with the chair of the practice Patient Participation Group. The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 19 January 2015. During our visit we spoke with GPs, members of the nursing team, the practice manager, reception and administrative staff. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards were made available at the surgery prior to inspection.

Good

Are services safe?

Our findings

Safe track record

The practice 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 one nurse discussed with us an incident she had been involved in and how the incident had been investigated and the action identified. She confirmed that the actions had all been completed to try to limit the chance of the incident reoccurring.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two financial years. 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. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standing item on the practice clinical 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 practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result including retraining and circulating any new guidance to ensure all staff were up to date with new guidance. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the electronic records systems 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 staff meetings especially if they had been dealt with by the medicines management team at the Clinical Commissioning Group (CCG) to ensure staff were aware of any that was 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. All staff were trained to a level appropriate to their role. Staff told us their training was due to be updated at the end of the month and they already had protected time to do this. 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 an appointed dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who this 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. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Information was available to make staff aware of any relevant issues when patients attended appointments; however the flags were not evident as soon as the record was opened. The practice manager told us the electronic system was relatively new to them they were still finding ways to ensure details were instantly available to assist practitioners. We were assured they would address this as soon as possible. The lead safeguarding GP was aware of vulnerable children and adults and records

demonstrated good liaison with partner agencies such as the police and social services. The practice were able to show us their current figures for children and adults who were coded as 'at risk' or under 'protection' orders

GPs supplied information as requested to local case conferences for patients registered at their practice and attended as workload allowed.

Patients with high attendance records at A&E were followed up in a timely manner and these patients were invited in to see the GP where if appropriate, care plans were instigated to assist the patient to manage their conditions in a more appropriate way. We discussed a number of vulnerable patients who had been supported in this way by the clinical team and they had now successfully reduced their use of both the ambulance service and the local A&E department.

There was a chaperone notice and policy, which was visible in the waiting room and in consulting rooms. (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). The nursing staff usually acted as chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The clinical team had written protocols for each treatment that reception staff may need to act as chaperone for. These protocols explained what the procedure was, what it was for, how the patient would be positioned, what to look out for and how to support the patient.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

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, sedatives and anti-psychotic prescribing within the practice. One GP discussed with us their intention to audit the use of a particular drug group called Quinolones (used to treat serious bacterial infections) as their usage was above the CCG average, to check their prescribing data and reduce the use of the drugs where possible.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We discussed these processes with the GPs we interviewed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms used in the electronic system were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescription pads for handwritten prescriptions were kept secure at all timers but were not tracked appropriately.

All requests for repeat prescriptions were handles in line with the practice policy and protocol and weekly checks were made on uncollected prescriptions. These prescriptions were recorded on the patient's records as uncollected, disposed of securely and discussed with the patient at the next opportunity.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning was carried out by an external provider, 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.

The practice had a lead for infection prevention and control (IPC) who had undertaken training to enable them to provide advice on the practice infection control policy. The IPC policy and supporting procedures were available for staff to refer to, which enabled them to plan and

implement measures to control infection. This provided guidance on specific situations, for example, use of personal protective equipment, dealing with spillage of blood and responding to a needle stick injury. We saw there were adequate supplies of equipment available to staff to enable them to follow the protocols. Staff were able to describe how they would use these to comply with the practice's infection control policy

All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice had requested support from the local NHS Trust to carry out an IPC audit of the practice in the last six months and an action plan with improvements identified for action had been completed on time. Minutes of practice meetings showed that the findings of the audits were discussed with all staff groups.

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.

The practice had systems in place for segregation of clinical and non-clinical waste. There were sharps bins in each treatment room which were not readily accessible to patients. An external contractor attended the practice on a regular basis to collect clinical waste and remove it off site for safe disposal.

Clinical staff were responsible for maintaining infection control measures within their own consultation and treatment rooms during the course of the day. Regular monthly room audits were carried out and any actions were addressed in a timely manner. The lead told us that as part of the appraisal process they checked that members of the nursing team were up to date in their knowledge and understanding of cleaning requirements.

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 weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

All equipment used for minor surgery was single use and was checked for expiry date before use and safely and securely disposed of after use in line with practice policy.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place 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. Annual Leave for GPs was booked 12 months in advance to allow for appropriate cover to be obtained if it was necessary to use locum GPs.

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 were in line with planned staffing requirements.

The practice had recently taken a large number of patients from another closing GP practice list and as such had identified a need to increase their GP clinic capacity. This post was at the time of the inspection being actively recruited in to. Partner GPs were currently covering this extra demand for appointments.

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 annual and monthly 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.

Identified risks were included on a risk log. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

All patients requesting urgent on the day appointments were seen at some point during the day of their request, these appointments were five minutes in length and designed to address specific urgent issues that could not wait for a routine appointment.

We were given examples of where a patient with a long term condition regularly, sometimes daily, called the ambulance service and accessed A&E at the local NHS Trust. The GPs and nursing team had discussed the patients' needs with them and had agreed a new care plan. This meant they could, during practice hours ring the reception and make arrangements to be seen by the nurse or GP available to treat the patient and assist them not to attend A&E. This had reduced their A&E attendance dramatically. There were a number of these care plans in place to assist patients in this way.

The practice had clear guidelines on repeat prescriptions for patients with long standing conditions and checks were made to ensure the patients were managed within these guidelines. Patients on complex or restrictive medication were given limited amounts of their medication to ensure safety of the person and the medicine. An example of this was Warfarin which is a blood thinning agent, this was only given in sufficient amounts to get the patient to their next blood test.

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. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available 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 also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. 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. The practice manager had recently agreed with a neighbouring practice contingency arrangements if there any premises issues. This would ensure patients requiring attention could be seen by a GP or nurse.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners, the Clinical Commissioning Group (CCG). We saw minutes of practice meetings where new guidelines were shared, the implications for the practice's performance and patients were discussed and required actions agreed. Some staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. Some staff did not get the opportunity to attend clinical meetings due to their work patterns. We discussed with the practice manager the need to rotate these meeting days to allow the staff member to attend and ensure they are fully involved in benchmarking exercises to improve patient outcomes.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. All new patients were offered health assessments with the nurse and GP when they joined the practice.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. 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 continually review and discuss new best practice guidelines for the management long term conditions. Our review of the clinical meeting minutes confirmed that this happened.

We saw one practice nurse was being supported to carry out consultations with patients attending for urgent on the day appointments. The patients were triaged by the on call GP and then listed to see the nurse. This allowed the GP to see more complex urgent on the day patients and also allowed them to offer more on the day appointments for patients. The GP was available to discuss the individual patients in between seeing his own patients or if the patient was straight forward then they had allocated time at the end of the appointments to discuss the patients the nurse had seen.

Read coding was used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. These codes improve patient care by ensuring clinician's base their judgement on the best possible information available at any given time.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices

Referrals to secondary care were made in line with national standards. There were effective systems in place to ensure that all incoming post to the practice was coded, attached to the relevant patient's records and brought to the attention of the GP in a timely manner, this was carried out via the electronic system and was track able through the system. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All the GPs we spoke with used national standards for the referral of patients with for example suspected cancers referred and seen within two weeks. We saw feedback from peer reviews of referrals and the actions identified from these reviews had all been actioned. Where feedback related to a locum GP who had been working at the practice the locum was contacted and given the feedback as appropriate.

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

Patients' comments demonstrated they were extremely satisfied with the care and treatment they received at the practice. Staff said they could openly share concerns about clinical performance.

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

Good

Are services effective?

(for example, treatment is effective)

information staff collected was then collated by the practice manager to support the practice to carry out clinical audits. The practice needs to ensure all practice nurses are fully involved in this process

The practice had limited clinical audits available that had been undertaken in the last 2 years. They had collated data from a number of different sources to support their practice but little of this had been formed into an actual audit cycle. They were planning a programme of audits for the coming year which included an audit of infection rates in minor operations and an audit of the use of use of a particular drug group called Quinolones (used to treat serious bacterial infections) as their usage was above the CCG average, the aim was to check their prescribing data and reduce the use of the drugs where possible.

One completed audit had been carried out to check the information given to patients regarding the effectiveness of Macrolide antibiotics in patients who were also taking Statins which are drugs used to lower cholesterol. 11 patients were audited and asked the information they had been given regarding stopping taking their statins whilst taking the antibiotic. Information was shared with other GPs to remind them of the optimisation issues regarding drug interactions with these medicines. A further audit was carried six months later with 19 patients which suggested patients were being given more information and asked to stop the statins. This would be kept under review as an on going audit.

Cervical smear audits were carried out annually for the nursing team with actions identified for smears which were deemed inadequate. From these results further training was offered to the nurse and further audit carried out six months later.

Another audit/ data collection confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The practice manager 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 in a CCG audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs, the practice had shown results below the CCG average.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 97% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). 98% of patients with learning disabilities had had annual health and medication checks. With 100% of patients with a diagnosis of peripheral arterial disease (a build-up of fatty deposits in the arteries) and Osteoporosis (a condition that weakens bones) having had annual medication and health checks. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of appraisal, peer review, 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 quality improvement.

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

The practice was able to demonstrate they had reduced the number of attendances at A&E for a number of patients by introducing a care plan agreed with the patients for immediate care when the patient would usually have rung

for an ambulance. This plan encouraged the patient to contact the surgery rather than dial 999 and offered them an appointment to see either the nurse or GP to address their immediate needs.

The practice also participated in local benchmarking completed by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. One area the practice has excelled in for example was the practice had managed to save 14% on their medication budget compared to other practices in the area.

The practice had been commended by the local CCG for 81.6% of their referrals being classed as high quality by their peers at peer review in 2014.

Effective staffing

All the patients who provided feedback were complimentary about the staff. We observed staff were competent, comfortable and knowledgeable about the role they undertook.

The practice had a formal induction process for any new staff joining the team. New members of staff completed an induction programme tailored to meet the requirements of their role.

Practice staffing 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. All GPs were up to date with their yearly continuing professional development requirements and were waiting for 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 staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example smear training and updates and diabetes management.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles (for example seeing patients with long-term conditions such as asthma and COPD) were also able to demonstrate that they had appropriate training to fulfil these roles. One nurse was being supported by a GP to see patients attending for urgent on the day appointments with a view to taking on this role for triaged patients in the future.

The staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

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 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 from communications with other care providers 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 were no instances identified of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings quarterly or as required to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses, other professionals as appropriate and decisions about care planning were documented in a shared care record.

The practice had close working relationships with four other practices in the area and offered support as required to these practices.

Good

Are services effective?

(for example, treatment is effective)

The practice had one residential/nursing home within its locality and attended patients as requested.

Information sharing

The practice used an electronic system 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. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Some GPs dictated letters for referral to other professionals and these were typed and sent within 24 hours of the consultation by the medical secretary.

The practice has 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 a recently installed electronic patient record to coordinate, document and manage patients' care. All staff were trained on the system, and commented positively about the system's safety and ease of use; however further training had been arranged to allow the system to be used to its full potential. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice held monthly management meetings and GPs and the practice manager met regularly with nursing staff. The practice nurse weekly meeting would need to be rotated across a number of days to allow all nurses to attend. Non-clinical staff met together, the practice manager attended all groups of staff meetings and fed back to the partners any issues highlighted. Information about risks and significant events was shared openly and honestly. One GP attended Clinical Commissioning Group meetings and shared information from these with the staff. This kept staff up to date with current information about local enhanced services and requirements in the community.

The practice website included information for patients about services available at the practice, signposting to other healthcare providers and support groups, and latest news. Similar information was displayed on site.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us 60% of care plans for patients with learning disabilities had been reviewed in last year. 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 this included the use of pictorial letters for learning disability patients when they were recalled for medication review. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal and written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. An audit to review the process that confirmed the consent process for minor surgery had being followed was due to be undertaking in the coming year.

GPs and nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation. The programme of e-learning available to staff included modules on mental capacity, learning disability and dementia awareness. The practice had identified where this training was relevant to a staff

Good

Are services effective?

(for example, treatment is effective)

member's role and there was an expectation that it would be completed. The training records we looked at showed that some members of staff had already completed, others remained outstanding

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. 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 chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. In our discussion with the practice nurse team they informed us that the GP would see any new patient as a matter of urgency if they had risk factors for disease identified at the health check. They would then schedule further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all patients had been offered an annual physical health check. Practice records showed 60% had received a check up in the last 12 months.

The practice's performance for cervical smear uptake was 82.63% against a national average of 81.83, which was better than others in the CCG area. The local scorecard data for the practice for 2014 shows their position as fifth out of 37 practices in the CCG area.

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 for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

There was a clear policy for following up on non-attenders for all missed appointments.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey a survey of 170 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. 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 rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and 89% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive but this was the only negative comment we received either verbally or in writing. We also spoke with 8 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment rooms were away from the main reception area and 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 in a confidential area behind a door at the rear of the reception desk and staff spoke quietly if answering any calls at the reception desk to ensure patient information was not overheard. Staff asked patients for details to check their identity but did not repeat this

information back, which helped keep patient information private. Patients were encouraged to use the electronic booking in system to reduce the need for them to share their personal details verbally in the waiting area. Patients were encouraged to wait a short distance from the reception desk if they wished to speak to the receptionist. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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 if any areas of concern were raised they would be fully investigated and any learning actions would be shared will all staff groups. We were shown an example of a report on a recent incident 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 they did not often have to deal with difficult situations but felt referring to this would help them diffuse any potentially difficult situations that may arise.

Patients attending with learning difficulties were well known to the staff so they could assist them with their needs without the need to disclose any sensitive information.

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, data from the national patient

Good

Are services caring?

survey showed 77% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results. Both these results were above average compared to national averages.

All the 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 patents this service was available.

We discussed with the GP's their care plans for patients involving end of life decisions and were informed this was completed with the patients and where they indicated their relatives. This information was updated every three months or before if circumstances changed. Any relevant information regarding end of life care was shared with out of hours services as appropriate.

We saw evidence of care plans where patients with long term conditions had been fully involved in their planning and where plans had been put in place to support the patient's immediate needs at times when their needs were greatest. This also involved avoiding unplanned admission to the local NHS Trust A&E by invoking the care plan and accessing the practice at short notice.

Patients we spoke with during the inspection who had children told us they felt their children and young people were treated in an age-appropriate way, recognised as individuals with their preferences considered. One patient told us their child was treated as an adult and given a fully explanation of the treatment being suggested and asked for their comments. They were pleased with this approach as it gave the child a chance to comment on their feelings. They told us the child was offered a choice of medicine or tablets and allowed to make their own decision.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, one member of the Patient Participant Group we spoke with said they had received help to access support services to help them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. They also told us they could access counselling and the GPs were happy to refer them if this was their wish. They told us they felt very supported by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Information from NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice had recently been involved in accepting patients from another practice list due to closure. The practice had been keen to accommodate these patients but did not want to disadvantage their own patients so had worked with the CCG to devise a strategy to allow them facilitate an easy transition of patients. This included the practice not offering every patient new patient checks as was normal practice and offering medication reviews instead to ensure patients could access their medication without interruption.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included a pictorial display of the faces of the clinical staff to allow patients to instantly recognise the GP or nurse when they met them, the introduction of a suggestion box in reception and the posting of emergency/useful contact numbers on the outside door of the practice to assist patients when the practice was closed especially at weekend. They had also introduced an 'information hub' in the waiting room when patients could access up to date information on the practice if they could not access the website. Patients had also suggested distraction tools for anxious patients waiting for minor surgery; the practice had supplied an MP3 player to try to address this and this had been well received by patients.

The practice had worked with patients to ensure their immediate care needs were responded to in an appropriate and timely manner by implementing care plans for a small number of patients who were statistically shown to have a higher than average attendance at A&E. By using these care plans they had now successfully reduced their use of both the ambulance service and the local A&E department.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had patients from a local learning disability residential home registered with them and used pictorial letters and leaflets to communicate with this group of patients.

The practice had access to online and telephone translation services however these were rarely used. We spoke with a patient who was not of English decent and they told us the GP took time to ensure they understood what was being advised and they did not feel they needed any other support

The practice meetings minutes demonstrated that equality and diversity was regularly discussed.

The practice was situated on the ground and basement floors of the building with most services for patients on the ground floor. There was lift access to the basement floors. The premises and services had been adapted to meet the needs of patient with disabilities. There was ramp access at the front of the building and lift access to other floors as required. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams. Some of the corridors used to access consulting rooms were narrow but staff told us they always assisted patients with wheelchairs or prams without being prompted it was 'second nature' to them. The fire escape on the basement floor had steps up to the muster pint and there were ramps available to allow wheelchair and pram access for evacuation if required.

The practice had a population of 5.3% of patients from backgrounds other than British but staff assured us most spoke or could understand English and if needed it could cater for other different languages through translation services.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available from 08.30 am to 5pm on Monday, Tuesday and Friday and available until 7.40pm on Wednesday and Thursday. Urgent on the day appointments were available everyday with either the GP or nurse.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. 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. Essential telephone numbers were displayed on the practice door when the practice was closed to assist patients to access services.

Longer appointments were also available for patients who needed them and for those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to one local care homes as requested to those patients who needed to be seen.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said 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 were able to make appointments on the same day of contacting the practice. For example, we observed a patient who requested an appointment for the next week being offered an appointment the day after the inspection with a GP of their choice as their scope for appointment time was limited due to child care commitments. The receptionist attempted to accommodate the patient as requested but could not arrange a suitable time so offered an earlier date appointments at the requested time which was gratefully accepted.

The practice's extended opening hours on Wednesday and Thursday was particularly useful to patients with work commitments. This was confirmed by comment card feedback we received stating this was a service they took advantage of every time they needed to see a GP and it was easier for them as they did not need to take time off work. On the day appointments were available after 4pm to allow children and young people to be seen should they require, after their school day.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system posters were displayed and the website contained information on making complaints.. 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 11 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, in an open and transparent manner. All complaints were discussed at staff meetings and also shared with the patient participation group; we were able to see minutes to demonstrate this. Action plans were formulated and dated as completed for accuracy.

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.

We were told patients had commented that the seating in the waiting room, once refurbished was difficult for limited mobility patients to access and they had suggested removing some chairs. To address this, the practice manager had labelled the chairs in the front of the waiting area for patients with limited mobility or those requiring assistance.

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 details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to always offer a friendly, caring good quality service that was available and accessible to all patients.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice minutes from the last 12 months and saw the vision was discussed at all meetings and staff told us they all felt they owned part of this. Part of this vision was a culture of excellence in all areas and although staff acknowledged this could bring added pressure they all felt it a valuable and essential part of the strategy.

Governance arrangements

The practice had 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 10 of these policies and procedures and staff we spoke confirmed they knew where to access them and had read and understood them. All 10 policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight 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. Staff who had raised concerns or been involved in serious adverse events told us they felt support when going through the process.

The practice used the Quality and Outcomes Framework (QOF) 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 nurse told us about a local peer review system they took part in with other practice nurses from the same CCG area.

We looked at the report for the practice from the last peer review from the CCG on prescribing data, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement. The practice was shown to have an effective prescribing policy and had managed to save money in the last financial year. The only red area identified for the practice by the CCG on their scorecard (the benchmarking tool used by the CCG) was to have an in-depth infection prevention audit carried out and this had been addressed and the action plan had been completed in a timely manner.

The practice had an on going programme of data collection and clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice was currently formatting an audit calendar for the next year to include audits on infection rates following minor surgery, looking at the GP prescribing of Quinolones. As well as an audit of minor dermatological cases needing further follow-up by the NHS Trust dermatology team after having minor surgery at the practice.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log he used. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risks discussed included the building, the environment, medicines management, staffing, equipment and a range of emergencies that may impact on the daily operation of the practice. Examples included flood, pandemic, fire and terrorism. We saw that risks to both service and staffing changes (both planned and unplanned) were included

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Reporting structures were well defined and understood. Staff we spoke with understood their roles and were clear about the boundaries of their abilities. They were aware of each other's responsibilities and who to approach to feedback or request information.

Staff told us they felt well supported and valued. We found that staff knew and understood the practice vision and

Are services well-led?

Good

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

values, and what their responsibilities were in relation to it. From our conversations with staff during the inspection it was clear the team was fully committed to achieving it with a can do approach. It was also clear the practice had a dedicated and cohesive team of staff who had mutual respect for each other.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice manager told us that each primary healthcare team meeting included an open floor session for staff to make suggestions, provide feedback or raise concerns. Staff we spoke with confirmed such opportunities were available and that they felt comfortable in doing so. The practice nurse meeting was always held on the same day and needed to be rotated to allow all staff to attend the practice manager informed us this would be addressed immediately.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys carried out with the PPG, suggestion box comments, compliments and complaints received. We looked at the results of the annual patient survey. We reviewed a report on comments from patients from the suggestions box between June and December 2014, which did not have a common theme. The practice manager showed us improvements that had been made to the waiting area, and the replies sent to the patients who had added their names to the comments. Anonymous comments were added to the survey results were made available to the public in the waiting room.

The practice had an active virtual patient participation group (PPG) which had steadily decreased in size. The PPG included representatives from various population groups; but not from the younger population groups. Promotion of the group was evident in the waiting areas of the practice and had been promoted at recent flu vaccination clinics to try to encourage other population groups to join. The PPG had carried out quarterly surveys and communicated either electronically or in writing every month. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website and in the waiting rooms.

The practice had gathered feedback from staff generally 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. The practice had a staff nomination scheme where staff members could nominate colleagues if they felt they had acted over and above their role. The nomination was considered by the partner GPs at their meeting and the staff member was rewarded in a small way. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

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

Newly employed staff completed a period of induction. Learning objectives for existing staff were discussed during annual appraisal and mandatory training was role relevant.

The practice completed reviews of significant events and other incidents. Practice documentation showed evidence of learning being shared across the practice. A structured programme of meetings provided a regular forum for this.