Selston Surgery

Quality Report

139 Nottingham Road, Selston, Nottinghamshire
NG16 6BT
Tel: 01773 810226
Website: www.selstonsurgery.org

Date of inspection visit: 14 July 2015
Date of publication: 01/10/2015

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Selston Surgery on 14 July 2015. Overall the practice is rated as good.

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

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

- Feedback from patients was continually positive about the care and treatment they received, and the way staff treated them. They said that they were treated with kindness, dignity and respect.
- Patients were able to access care and treatment when they needed it, and could access appointments and services in a way, and at a time that suited them.
- The practice was accessible and well equipped to meet patients' needs.
- There was a holistic approach to meeting patients' needs. The practice had strong links with other providers and organisations to aid communication, and multidisciplinary working to meet patients' needs.
- Overall, systems were in place to keep patients safe and to protect them from harm. The recruitment procedures have been strengthened to ensure that all staff working at the practice were suitable to carry out the duties required of them.
- Patients felt listened to and able to raise concerns about the practice. Concerns were acted on to improve the service.
- There were high levels of engagement with patients and the patient participation group (PPG) to improve the services. The PPG was actively involved in the planning and delivery of services.
- There was an open, positive and supportive culture.

Summary of findings

- The practice had a motivated and experienced team; staff were supported to develop their knowledge and acquire new skills. However we found that not all staff had been assessed as competent to carry out all tasks delegated to them.
- The services were well-led. Overall, systems were in place to assess and monitor the quality and safety of services that people received.

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

Importantly the provider must

Ensure that all staff providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely.

Also, the provider should

Strengthen the systems for monitoring the service including recruitment procedures and checks to ensure the defibrillator is working.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

The practice was open and transparent when things went wrong. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, and addressed. Learning took place and appropriate action was taken to minimise incidents and risks. The practice was clean and suitably maintained.

Overall, systems were in place to keep patients safe and to protect them from harm. The recruitment procedures have been strengthened to ensure that all staff working at the practice were suitable to carry out the duties required of them. However, we found some staff had been delegated certain tasks, which they had not been assessed competent to perform and were not within their job description.

Are services effective?

Good

The practice is rated as good for providing effective services.

The practice had a motivated and experienced team with appropriate knowledge and skills to enable them to carry out their roles effectively. The appointment of nurse prescribers had allowed for more holistic nurse-led patient care. Staff worked closely with other providers and staff to meet patients' needs. Patients' care and treatment was delivered in line with evidence based practice.

Importance was given to health promotion and prevention and supporting patients to self-manage their conditions, where able. The practice had a system in place for completing clinical audit cycles, to provide assurances that patients were receiving effective care and treatment, and to improve outcomes where needed.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients was consistently positive about the level of care and the way staff treated them. Patients were treated with kindness, dignity and respect, and were actively involved in decisions about their care and treatment. Relationships between staff and patients were very positive and supportive.

Patients' emotional and social needs were seen as important as their physical needs. Data showed that patients rated the practice

Summary of findings

highly for virtually all aspects of care. We observed a patient-centred culture. Patients' privacy, dignity and confidentially were maintained. Staff were caring, respectful and polite when dealing with patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The services were flexible and delivered in a way that met the needs of the local population. Patients were able to access appropriate care and treatment when they needed it, and could access appointments and services in a way and at a time that suits them. The practice opened between 6.45am and 8pm on Thursday to accommodate extended appointments and consultation times. Patients could also access telephone consultations and a daily 'drop in' service for minor issues, where an appointment was not required, between 8am and 9.30am. They also had access a nearby walk in service, which was run by local GPs.

There was a culture of openness and people were encouraged to raise concerns. Patients' concerns and complaints were listened to and acted on to improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led.

There were high levels of engagement with patients and the patient participation group (PPG) to improve the services. The practice had a clear vision to deliver high quality care and services for patients, which was shared by the staff team. There was effective teamwork and a commitment to improving patient experiences. The practice had a highly motivated staff team to enable them to deliver well-led services. The leadership had been strengthened by the appointment of two advanced nurse practitioners. Staff were supported to develop their knowledge and acquire new skills to provide high quality care.

There was an open, positive and supportive culture. Overall, systems were in place to assess and review information about the quality and safety of services that people received. However, we highlighted areas where the systems required strengthening.

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 over 75 years were invited to attend an annual health check, and had a named GP to provide continuity of care and ensure their needs were being met. The practice worked closely with other services to enable patients to maintain their independence and remain at home, where possible. Staff carried out active screening, to support early referral, diagnosis and treatment of osteoporosis to help reduce the risk of fractures amongst older people.

The practice kept a register of people who had complex needs and required additional support, or were at risk of admission to hospital. Care plans were in place, to ensure that patients and families received appropriate care, and to help minimise the need for admission to hospital. Elderly patients were recalled for a yearly flu vaccine and were also offered the pneumococcal and shingles vaccine. Home visits were carried out to patients unable to attend the practice. Carers were identified and supported to care for older people.

People with long term conditions

Good

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

Patients were offered an annual health review. They also had a named GP to provide continuity of care and ensure their needs were being met. The practice nurse had the lead role in managing long-term conditions and completing patient reviews, having received appropriate training. Patients were educated and supported to self-manage their conditions, where able.

The clinical staff worked closely with specialist teams to meet patients' needs, and kept a register of patients with complex needs requiring additional support. Patients' conditions and other needs were reviewed at a single appointment where possible, rather than having to attend various reviews. When needed, longer appointments and home visits were available. Carers were identified and supported to care for people with complex long-term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Summary of findings

Priority was given to appointment requests for babies and young children; they were seen the same day if unwell. Systems were in place for identifying and following-up children at risk of abuse, or living in disadvantaged circumstances. The practice worked in partnership with their named midwife and health visitor and school nurses to meet patients' needs.

The 2013 to 2014 data showed that immunisation rates were 100% for all standard childhood immunisations. Children and young people were able to attend appointments outside of school and college hours. The practice provided maternity care and certain family planning services. The practice also provided advice and screening on sexual health for teenagers.

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).

Extended opening hours were provided, which included early morning and evening. A daily 'drop in' service was also provided for minor health issues, where an appointment was not required. Patients also had access to a nearby walk in service on Wednesday evening and Saturday morning, which was run by local GPs. This enabled patients to access appointments and consultations in a way, and at a time and that suited them.

The practice offered a 'choose and book' service for patients referred to secondary services. This provided greater flexibility over when and where their test took place, and enabled patients to book their own appointments. Health checks were offered to patients aged 40 to 74 years, which included essential checks and screening for certain conditions. The practice also offered health screening appropriate to the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients whose circumstances may make them vulnerable. Patients had a named GP to provide continuity of care, to ensure their needs were being met. Patients were invited to attend an annual health check. They were also offered same day appointments or telephone consultations. When needed, longer appointments and home visits were available.

The practice worked closely with other services to ensure vulnerable people received appropriate care and support. Carers were identified and offered support. Patients and carers were told about how to access various support groups and organisations. Staff knew

Summary of findings

how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies.

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).

The practice held a register of patients experiencing poor mental health. Patients were invited to attend an annual health review, and had a named GP to provide continuity of care and ensure their needs were being met. Patients were offered extended or same day appointments or telephone consultations. When needed, longer appointments and home visits were available. The practice worked closely with relevant services to ensure that patients' needs were regularly reviewed, and that appropriate risk assessments and care plans were in place.

Patients were supported to access emergency care and treatment when experiencing a mental health crisis. The practice screened appropriate patients for dementia, to support early referral and diagnosis where dementia was indicated.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 33 completed cards. We also spoke with nine patients during our inspection. Feedback from patients was continually positive about the care and treatment they received and the way staff treat them. They described the staff as friendly, helpful and caring, and said that they were treated with kindness, dignity and respect. Several patients referred to the staff team and the service as excellent, first rate and professional.

Patients told us they were able to access appropriate care and treatment when they needed it. They described their experience of making an appointment as very good, with urgent appointments or telephone consultations available the same day. They also said that they did not have to wait long to be seen when attending the practice.

Patients said that they felt listened to, and able to raise any concerns with staff if they were unhappy with their care or treatment at the service, as the staff were approachable. They found the premises welcoming, clean and accessible.

We spoke with senior staff at the two main care homes where patients were registered with the practice. They were complimentary about the services provided, and said the practice staff were usually responsive to patients' needs.

The practice had an active Patient Participation Group (PPG), which actively sought feedback from patients and acted on this. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We spoke with two members of the PPG. They told us that they worked in partnership with the practice and had their full support, to ensure that patients' views were listened to, and acted on to improve the service.

The most recent data available for the practice on patient satisfaction included the practice's 2015 survey, which 301 patients completed, and the 2015 national GP patient survey, which 103 people completed. Both survey results showed high levels of patient satisfaction with the care and services they received. In almost all areas of the national survey the practice's results were higher than the local and national averages.

We also reviewed patient reviews of the practice on NHS Choices completed between October 2014 and June 2015. There were two positive comments; these referred to the practice as 'brilliant', easy access to appointments, waiting times in surgery were very good, friendly and helpful staff; reception staff went out of their way to help. One negative comment related to lack of care and attention following surgery and not feeling listened to. The practice manager assured us that action had been taken in response to the feedback

Areas for improvement

Action the service MUST take to improve

Ensure that all staff providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely.

Action the service SHOULD take to improve

Strengthen the systems for monitoring the service including recruitment procedures and checks to ensure the defibrillator is working.

Selston Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector, two specialist advisors including a GP and a practice manager, and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Selston Surgery

Dr Shashi Bassi is a single handed male GP who manages Selston Surgery at 138, Nottingham Road, Selston, Nottinghamshire. He provides primary medical services to approximately 4,800 patients in the Selston area. The practice population includes 20% of patients aged 65 years and over.

The staff team includes six administrative staff, an apprentice administrator, a practice manager, an assistant practice manager, two nurse practitioners, a practice nurse, two health care assistants and a male GP. Three male locum GPs also provide medical support to the practice. The arrangements for seeing a female clinician includes two female advanced nurse practitioners.

The practice holds a Primary Medical Services (PMS) contract to deliver personal medical services. The practice also has a contract to provide a number of enhanced services, which aim to provide patients with greater access to care and treatment on site.

The practice is open between 8am and 6.30pm Monday, Tuesday and Friday. On Wednesday it is open from 8am until 1pm, and on Thursday it is open from 6.45am until 8pm to accommodate extended appointments and consultation times. Patients can also access telephone consultations and a 'drop in' service for minor issues, where an appointment is not required, between 8am and 9.30am Monday to Friday. They can also access a walk in service on a Wednesday evening from 6.30pm to 8.30pm, and Saturday mornings from 9am to 12.30pm at a nearby Health Centre, which is run by local GPs. This enables patients to see a local GP outside of the practice's opening hours.

The practice does not provide out-of-hours services to the patients registered there. During the evenings, at weekends and after 1pm on Wednesday an out-of-hours service is provided by Central Nottinghamshire Clinical Services (CNCS). Contact is via the NHS 111 telephone number.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People whose circumstances may make them vulnerable

• People experiencing poor mental health (including people with dementia)

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We spoke with senior staff at the two main care homes where patients were registered with the practice. We also obtained feedback from three external staff who worked closely with the practice. We carried out an announced visit on 14 July 2015.

During our visit we checked the premises and the practice's records. We spoke with various staff including the practice nurse, an advanced nurse practitioner, the healthcare assistants, the GP provider and a locum GP, reception and administrative staff and the practice manager and deputy practice manager. We also received comment cards we had left for patients to complete and spoke with patients and representatives who used the service.

Requires improvement

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. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

A system was in place to ensure that staff were aware of national patient safety alerts and relevant safety issues, and where action needed to be taken. Alerts were also discussed at practice meetings to ensure all staff were aware of issues.

Records showed that safety incidents and concerns were appropriately dealt with. For example, the clinical staff and the pharmacist attached to the Clinical Commissioning Group (CCG) medicines team, had responded to a national safety alert about a medicine, used to treat nausea and vomiting. All patients prescribed the medicine had been reviewed as directed in the safety alert.

We reviewed safety records and incident reports for the last two years. This showed the practice had managed these consistently over time, and so could evidence a safe track record.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff we spoke with said that they had received recent safeguarding training specific to their role. For example, the GPs had completed level three children's training and vulnerable adults training. Records we looked at supported that staff had received appropriate training.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children, and who to speak to in the practice if they had a safeguarding concern. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies. Contact details were available to staff.

There was a lead GP for safeguarding vulnerable adults and children. They could demonstrate they had had the necessary training to enable them to fulfil this role. We checked the records relating to recent safeguarding issues. These showed that the practice had liaised with relevant professionals and agencies to share essential information about vulnerable patients. Staff had recorded information about patient's welfare in their electronic record.

All staff had undertaken IRIS (Identification and Referral to Improve Safety) training on domestic violence and abuse, to further improve their awareness, recording of disclosures and referrals involving domestic violence to appropriate agencies.

Patients' individual records were managed in a way to keep people safe. All information about patients was kept on the electronic system. Records showed that multi-disciplinary safeguarding meetings were held every eight weeks, to share information and discuss children and adults who were vulnerable and at risk of harm.

We saw that an alert system was in place to highlight vulnerable patients on the practice's electronic records, and to ensure that risks to children and young people were clearly flagged and reviewed. The system ensured they were clearly identified and reviewed, and that staff were aware of any relevant issues when a patient or their next of kin attended appointments or contacted the practice. However, a locum GP we spoke with said that they were not aware of the read codes and the alert system in place. The practice assured us that all locums were informed of this as part of their induction. They agreed to re-affirm this with the three locums working at the practice.

A chaperone policy was available, which was visible to patients at the surgery but not on the practice's web site. (A chaperone is a person who acts as a safeguard and witness for a patient and a health care professional during a medical examination or procedure**)**.

The nurses and the health care assistants at the practice had been trained to be a chaperone. Records were available to show that they had a satisfactory disclosure and barring (DBS) check. A DBS check helps prevent unsuitable staff from working with vulnerable people, including children.

Staff we spoke with were aware of their responsibilities, including where to stand to be able to observe the examination. Non-clinical staff had also received chaperone training with a view to undertaking this role. Records showed that the practice had applied for an

appropriate DBS check for all non-clinical staff. The practice manager assured us that the staff would not undertake chaperone duties until a satisfactory DBS check had been obtained.

Medicines management

Several patients told us that the system for obtaining repeat prescriptions worked well, to enable them to obtain further supplies of medicines.

Procedures were in place to protect patients against the risks associated with the unsafe use of medicines. For example, regular checks were carried out to ensure that medicines including vaccines were within their expiry date and suitable for use. All the medicines we checked were in date. Expired and unwanted medicines were disposed of in line with waste regulations.

We checked medicines stored in the treatment rooms including the medicine refrigerator. We found that medicines were stored securely and managed appropriately, and were accessible only to authorised staff.

A policy was in place to ensure 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. An electronic data logger recorded the temperature of the vaccine refrigerator, which staff monitored. Staff also manually checked the temperatures each day, as a further assurance the medicines were kept at the required temperatures.

The nurses administered vaccines using directions that had been produced in line with national guidance. We saw evidence that they had received appropriate training to administer relevant vaccines. The health care assistants administered the flu vaccines to adult patients. Records showed that they had received appropriate training and had been assessed competent to administer this.

Records indicated that the health care assistants (HCAs) had been delegated certain tasks, which they had not been assessed competent to perform and were not within their job description. For example, a HCA had typed up a new prescription for an antibiotic for a patient, which the GP dictated in their presence, checked and authorised. They had not been assessed as competent to undertake this role. The provider agreed to review the role of the HCA's to ensure they are only delegated clinical tasks that they have received training and assessed competent to perform, and are within their role.

Staff told us that all prescriptions were checked and signed by a GP before they were given to the patient. We saw that arrangements were in place to ensure the security of blank prescription forms, which enabled them to be tracked through the practice and kept securely at all times.

A system was in place to oversee the management of high risk medicines, which included regular monitoring in line with national guidance. We checked the records of several patients who were prescribed a high risk medicine. The records showed that they had received appropriate blood tests and monitoring, to ensure that their medicines were managed safely.

The practice worked with the Clinical Commissioning Group (CCG) medicines team, to ensure that medicines were managed safely. The medicines team carried out regular audits, to check that patients' medicines were prescribed appropriately.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning schedules were in place and records were kept to ensure that the practice was hygienic. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to apply appropriate measures. For example, personal protective equipment including disposable gloves, aprons and spillage kits were available for staff to use to comply with the policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice nurse had taken on the lead role for infection control; they demonstrated that they had the necessary training to enable them to fulfil this role. Staff we spoke with told us they received training on infection control on induction; they also received regular updates. Records we looked at showed that staff had attended recent training.

Requires improvement

Are services safe?

An external provider had completed a comprehensive infection control audit in May 2014, which identified various areas requiring improvement. The practice had completed an action plan to ensure that the areas requiring improvement from the audit had/were being addressed.

The external audit had advised that the practice complete an annual audit to monitor the standard of cleanliness, and ensure that appropriate practices were being followed. The practice nurse showed us an infection control audit, which they were due to complete with the practice manager by the end of August 2015. An annual audit would then be completed.

The practice had a policy relating to the immunisation of staff, including the risk of exposure to Hepatitis B infection, which could be acquired through their work. The lead for infection control had identified that the immunisation records were not up-to-date; to show that all relevant staff were protected from relevant infections including Hepatitis B. The practice manager and lead nurse assured us that they were updating the records to provide evidence of this.

The practice had a policy for the testing and management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records were kept to show that control measures and regular checks were carried out in line with the policy, to reduce the risk of legionella infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly, and we saw records that supported this. A schedule of testing was

in place. We saw evidence to show that relevant equipment had been calibrated and checked recently. However, records were not available to show if the defibrillator (used to attempt to restart a person's heart in an emergency) had been calibrated and checked in line with the manufacturer's recommendations to ensure it worked properly.

Following the inspection, we received assurances that the defibrillator had been recently checked, although records were not available to show this. The practice had arranged for the relevant company to re-calibrate and check the equipment on 22 July 2015 and provide evidence of this.

Staffing and recruitment

The recruitment policy did not set out all the standards the practice followed when recruiting new staff. Following the inspection, we received an updated policy that essentially detailed the various stages of the process and required checks and information obtained.

We reviewed the personal files relating to a locum GP and two staff members recruited in the last 18 months. We found that the recruitment procedures required strengthening to ensure that the staff files contained all appropriate checks and information, prior to them commencing work to support their suitability to carry out their role. For example, the files did not contain satisfactory information about any physical or mental health conditions, which are relevant to the person's ability to carry out their work.

Two staff files relating to a locum GP and a self-employed nurse, who had recently started work at the practice, did not contain satisfactory references. Following the inspection, we received written assurances that appropriate references had since been obtained in regards to both staff, which provided evidence of conduct in their previous employment and their suitability to carry out their work.

Staff told us that they had attended an interview to support their suitability to work at the practice. However, the files did not contain a summary of their interview, to show that robust and fair procedures were followed.

Following the inspection, we received assurances that the recruitment procedures had been strengthened to include all the required checks and information when employing new staff.

A policy was in place for checking nurses and GPs qualifications and registration to practice. Records showed that appropriate on-line checks had been carried out, to ensure that the nurses and GPs remained registered to practice with their relevant professional bodies, in line with the policy.

We found that arrangements were in place to ensure sufficient numbers and skill mix of staff were on duty. A rota system was in place to ensure that enough staff were on duty. Staff covered each other's annual leave and absences, where possible.

Requires improvement

Are services safe?

The patient list had not changed significantly. Staff told us there were enough staff to keep patients safe and maintain the smooth running of the practice. Various staff had worked at the practice a considerable number of years, which ensured continuity of care and services.

The single handed GP provided primary medical services to approximately 4,800 patients. They assured us that they were actively trying to recruit a salaried or partner GP, to further develop the services and meet the demands on the service. Due to difficulties in recruiting GPs, three regular locum GPs who were known to the provider, were providing medical support to ensure continuity of care and services. A written contingency plan was not set out in regards to recruiting additional GPs, and maintaining safe and effective care to patients in the absence of the single handed GP.

Monitoring safety and responding to risk

Systems and policies were in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the premises, equipment, staffing, dealing with emergencies and the management of medicines. We saw that various health and safety risk assessments had been completed, including actions required to reduce and manage the risks, which may impact on the ability to deliver services to patients.

Records showed that essential health and safety checks were carried out. For example, the fire alarm system was regularly serviced to ensure it worked properly. Records also showed that the premises were appropriately maintained. Following the inspection, we received assurances that the provider had arranged for the periodic inspection and associated testing of the electrical installations to be carried out by 10 August 2015.

The staff we spoke with were aware of the procedure in place at the practice if a patient, visitor or member of staff was taken unwell suddenly, and for identifying acutely ill children to ensure they were seen urgently. Staff gave examples of how they enabled patients experiencing a mental health crisis, to access urgent care and treatment. The practice also monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff we spoke with told us they had received recent training in basic life support. Records we looked at supported this.

We saw that 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). We found that processes were in place to ensure the equipment was tested and maintained regularly, except for the defibrillator. The defibrillator battery was not working, which meant it was not charged and available to use in the event of an emergency. The GP brought across a charged defibrillator, which was kept at the nearby health centre, which staff had access to. Following the inspection, we received assurances that a new battery had been fitted to the practice's defibrillator.

Emergency medicines were also available in a secure area of the practice and all staff knew of their location. Processes were 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. The emergency medicines included those for the treatment of common cardiac conditions, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). It also included other suggested essential medicines GP practices should hold in line with local guidance.

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Actions were recorded to reduce and manage the various risks. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

A fire risk assessment had been carried out and reviewed recently, which included actions required to maintain fire safety. Staff we spoke with told us they had received recent training, and that they practised occasional fire drills to ensure they knew the procedure in the event of a fire. Records we looked at supported this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us they received effective care and treatment. They also said that they were referred appropriately to other services when needed.

Discrimination was avoided when making care and treatment decisions. Interviews with clinical staff showed that the culture in the practice was that patients were cared for and treated based on need.

The GP and nurses could 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. However, a locum GP we spoke with said that they were not up-to-date with the guidance. The lead GP assured us that all locums were expected to be familiar with this. He agreed to affirm this with the locums working at the practice.

Staff told us that they discussed new guidelines and agreed changes to practice at clinical meetings, which were held every three months. Minutes of meetings we looked at supported this.

The practice knew the needs of their patient population well. There was a holistic and pro-active approach to meeting patients' needs, which was driven by all staff at the practice. We found from our discussions with the GP and nurses that they completed thorough assessments of patients' needs, which they reviewed along with the effectiveness of their care and treatment.

Management, monitoring and improving outcomes for people

The services were effective as all established staff had clear roles in monitoring and improving outcomes for patients. The roles included medicines management, data input, summarising patient records and scheduling clinical reviews.

The practice nurse undertook various clinical lead roles including long term conditions such as diabetes, asthma, and chronic obstructive airways disease. This enabled them to focus on specific conditions and improve outcomes for patients. The practice planned to further develop clinical lead roles, following the recent appointment of two advanced nurse practitioners.

Staff had key roles in monitoring 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). The practice used the information collected for the QOF, and performance against national screening programmes to monitor outcomes for patients.

The QOF performance data for 2013 to 2014 showed that the practice achieved a total of 97.2% in respect of their performance in measuring the clinical indicators assessed, which was above the national average of 93.5%. The practice's performance was above the national and local average in 18 out of the 20 clinical areas assessed. Where the performance was below national or local averages, staff had taken action to improve these areas.

The practice had a system in place for completing clinical audit cycles. The practice showed us four clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed, and the audit repeated to ensure outcomes for patients had improved. For example, an annual osteoporosis audit was completed to identify patients at risk of fractures and calcium and vitamin D deficiency, who may benefit from supplements or changes to their current medication in line with local and national guidelines. Following each audit, changes were made to patients treatment or care where needed, to help reduce the risk of fractures.

The practice's prescribing rates were similar to local and 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, and that the latest prescribing guidance was being used.

Effective staffing

Staff told us they worked well together as a team. Our findings supported this. The practice had a motivated and experienced team to enable them to carry out their roles effectively. This ensured continuity of care and services.

Good

Are services effective?

(for example, treatment is effective)

The skill mix of staff had increased to meet the demands on the service. An additional receptionist and administrator had been appointed, as well as an apprentice administrator. Two self-employed advanced nurse practitioners had also been appointed. The appointment of nurse prescribers had allowed for more holistic nurse-led patient care.

The practice was also actively looking to recruit a salaried GP or partner, to meet the demands on the practice and further develop the services. In view of difficulties in recruiting GPs, three regular self-employed locum GPs were providing medical support to the practice in the interim period.

Staff told us they had received appropriate induction training to enable them to carry out their work, which they found helpful. We noted that the induction process and checklist in place for staff was brief and did not relate to specific roles to ensure that new staff received essential information to carry out their work. The induction was supported by a generic staff handbook, which contained a summary of various key policies along with essential information for staff.

Records showed that staff had attended various training relevant to their role. This included training the practice considered to be mandatory such as infection control, fire safety and basic life support. A monthly protected learning event was held, which staff were supported to attend.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the health care assistants (HCA's) were awaiting training on ear irrigation and spirometry (lung function tests), to develop their roles and enable them to carry out the tests at the practice. Following the training they would be observed undertaking the procedures to ensure they were competent to carry them out. Protocols would also be in place detailing the procedures, who the HCA refers to, and how they assess whether there are any contra-indications and if it's appropriate to carry out the test.

The practice nurse told us how she was supported to further develop her skills to meet patients' needs. such as administrating vaccines, cervical cytology and managing patients with long-term conditions. She was able to demonstrate that she had attended appropriate training and updates.

Staff told us that they received supervision through peer support and team meetings they attended. The practice nurse told us that opportunities to receive on-going clinical supervision had increased, following the recent appointment of two advanced nurse practitioners.

The GPs demonstrated that they were up to date with their yearly professional development requirements, and had a date or had recently undergone 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).

Working with colleagues and other services

Our findings showed that the practice worked closely with other service providers and staff to meet patients' needs.

The practice held monthly multi-disciplinary meetings with staff involved in patients care; to discuss adults with complex needs, including those at risk of harm or unplanned admission to hospital. The practice worked closely with a community matron, whose role was beneficial in providing a direct point of contact, and ensuring patients and families received integrated care.

The nurses had lead roles in the management of long-term conditions such as diabetes and asthma. The clinical staff worked closely with specialist diabetic, cardiac, and respiratory teams to meet patients' needs.

The practice was applying the gold standards framework for end of life care. It held a palliative care register and regular internal, as well as monthly multidisciplinary meetings to discuss and review the care and support needs of patients and their families. Staff involved in patients care attended the meetings.

Monthly children's meetings were also held to discuss all patients in vulnerable circumstances and at risk of abuse. These meetings were attended by the practice's clinical staff, health visitor, midwife and school nurse, where able.

The practice had signed up to the enhanced service to help reduce unplanned admissions, patients who attended A & E inappropriately and to follow up patients discharged from hospital. Enhanced services are additional services

Good

Are services effective?

(for example, treatment is effective)

provided by GPs to meet the needs of their patients. Data showed that the practice had low levels of avoidable admissions and A & E attendances, compared to other local practices**.**

It was clear from discussions with the clinical staff that considerable work went into supporting people to remain in their own home, and ensuring they received appropriate support on discharge from hospital. A member of staff phoned patients with complex needs and those in vulnerable circumstances who had recently been discharged from hospital, to check how they were and if they required additional support.

Information sharing

The practice received test results, letters and discharge summaries from the local hospital and the out-of-hours services both electronically and by post. Procedures were in place to ensure that relevant staff passed on, read and acted 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. Arrangements were in place to follow up patients discharged from hospital.

Systems were in place to enable essential information about patients to be shared with other providers. For example, there was a shared system with the 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.

The practice was signed up to the electronic Summary Care Record, which provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. The practice 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.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment. They also said that they had the opportunity to ask questions and felt listened to.

Staff told us that they obtained informal consent from patients before they provided care or treatment. There was also a policy for obtaining written consent for specific interventions such as minor surgical procedures, together with a record of the benefits and possible risks and complications of the treatment.

We looked at the files of three patients who had had minor surgery recently. We found some inconsistencies in how formal consent and a record of the benefits and possible complications of the treatment was documented. The practice agreed to address this issue.

Staff gave examples of how a patient's best interests were taken into account if a patient lacked capacity to make a decision. For example, patients with learning disabilities were supported to make decisions through the use of care plans, with their involvement. Clinical staff we spoke with 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).

Clinical staff were also aware of the Mental Capacity Act 2005 and their responsibilities to act in accordance with legal requirements. They said that they had received relevant training to ensure they understood the key parts of the legislation, and how they applied this in their practice. We saw records to support this.

However, a locum GP we spoke with did not have a clear understanding of Gillick competencies, or the Mental Capacity Act 2005, and how to apply this in practice. The practice assured us that all locums were expected to be aware of this. The practice agreed to follow up this issue with the self-employed locums working at the practice. Following the inspection, we received assurances that the provider had updated the induction for locums, to ensure they had the information and knowledge to carry out their role.

Health promotion and prevention

Several patients told us the GPs and nurses gave them advice and guidance about maintaining a healthy lifestyle. We saw that health promotion information was available to patients and carers on the practice's website, and the noticeboards in the waiting area.

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with a health care assistant to all new patients registering with the practice. The GP was promptly informed of health concerns detected, and these were followed up in a timely way.

We found that patients were actively supported and educated to self-manage their conditions, to improve their compliance and health. For example, the practice nurse had supported a patient with type 2 diabetes to loose a significant amount of weight, by adopting a healthier lifestyle and eating. As a result of the changes their diabetes was now well controlled and they no longer needed to take medication. A further example included a patient who was supported to stop smoking. They had not smoked for the last two years, and their health and wellbeing had improved as a result of this.

An independent osteopath held a weekly surgery at the practice to enable patients to receive alternative treatments, where required.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice's data showed that under 50% of patients aged 40 to 75 years, had been offered, and attended a health check. The practice had put measures in place to improve the numbers of health checks offered to patients, and the uptake of patients who attend this.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2014 to 2015 data showed that the practice's immunisation rates had increased, and had achieved 100% for all standard childhood vaccinations in quarter four.

The practice was involved in various screening programmes including bowel, breast and cervical screening. National 2014 data showed that 81% of women aged 25 to 65 years had received a cervical screening test in the last five years, which was above the local average of 78.7% and the national average of 74.3%. Clinical staff told us that they carried out opportunist screening when patients attended the practice to see another clinician.

2014 data also showed that the practice achieved 82.6% uptake in breast screening rates, which was above the local average of 77.9% and the national average of 72.2%. They had also achieved 62% bowel screening uptake, which was above the local average of 59.5% and the national average of 58.3%.

The practice had various ways of identifying patients who needed additional support. They kept a register of patients with a learning disability, those experiencing poor mental health, those in vulnerable circumstances, those with long term conditions and older people. They were offered an annual health check, including a review of their medicines.

The register included 25 patients with poor mental health. Records showed that 15 patients had a comprehensive care plan in place to meet their needs, and all patients had been offered and had received an annual health check.

The register also included 14 patients with a learning disability. With the exception of a new patient, all patients had been offered an annual health check; 12 people had received this and one had declined the check. Where appropriate, the practice had involved the disability health co-ordinator to support patients to attend a health check.

The practice screened appropriate patients for dementia, to support early referral and diagnosis where dementia was indicated. The practice had a higher than average national prevalence of patients with dementia. Data showed that 70% of patients with dementia had received an annual health check.

The patient list included 20% of patients aged 65 years and over. The practice worked closely with local services including Age UK to support older people to maintain their independence and wellbeing. Clinical staff undertook active screening, to support early referral, diagnosis and treatment of osteoporosis to help reduce the risk of fractures amongst older people.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from patients was consistently positive about the care and the way staff treated them. They described the staff as friendly, helpful and caring, and said that they were treated with kindness, dignity and respect. They also said that they felt listened to, and that their views and wishes were respected.

Staff and patients told us that consultations and treatments were carried out in the privacy of a suitable room. We noted that conversations could not be overheard. We observed that patients were treated with dignity, respect and kindness during interactions with staff. Relationships between staff and patients were positive and supportive. Patients privacy and confidentially was also maintained. Confidential information was kept private.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2015 national GP patient survey, which 103 people completed. It also included the practice's 2015 survey, which 301 patients completed. The evidence from these sources showed that patients rated the practice highly in these areas. For example, data from the national GP patient survey showed:

- 87% said that they found the receptionists at this surgery helpful compared to the Clinical Commissioning Group (CCG) average of 87% and national average of 87%.
- 86% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 83% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%

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 this with the practice manager. A notice was displayed 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. All telephone calls were recorded, which provided a safeguard for patients and staff.

Care planning and involvement in decisions about care and treatment

Patients we received feedback from told us they were involved in making decisions about their care and treatment, and that their views and wishes were respected. They were given sufficient time and information during consultations to enable them to make informed choices.

The national GP 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:

- 82% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.
- 90% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 93% and national average of 90%.

The practice was signed up to the enhanced service to help avoid unplanned admissions to hospital. Enhanced services are additional services provided by GPs to meet the needs of their patients. Clinical staff assured us that all patients assessed at high risk of being admitted to hospital, including certain elderly patients and people with complex needs or in vulnerable circumstances, had a care plan in place to help avoid this. Patients care plans included their wishes, and where appropriate decisions about resuscitation and where they wished to receive end of life care. This information was available to the out-of-hours service, ambulance staff and local hospitals.

Patient/carer support to cope emotionally with care and treatment

The 2015 national GP patient survey information showed that patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 85% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.

Good

Are services caring?

- 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 92%.

Patients we spoke with and comment cards we received, were also consistent with the survey information. Several patients told us they received support and information to cope emotionally with their condition, care or treatment. They described the staff as caring and understanding. Where able, they were supported to manage their own care and health needs, and to maintain their independence.

We found positive examples to show that patients were supported to cope emotionally. For example, the lead GP regularly saw an elderly patient essentially to provide emotional support and listen to them.

The patient registration forms asked people if they looked after someone or if someone looked after them. Carers' details were included on the practice's computer system, to alert staff if a patient was also a carer to enable them to offer support.

We noted that information about bereavement services was available on the practice's website, including how to access a number of support groups and organisations.

Staff we spoke with demonstrated that importance was given to supporting carers to care for their relatives, including those receiving end of life care. Bereaved carers known to the practice were supported by way of a condolence card, personal visit or phone call from a member of staff who knew them best, to determine whether they needed any practical or emotional support.

We received feedback from two patients who had had a recent bereavement. They told us that they were treated with care, consideration and empathy and received personal support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice was responsive to their needs, as they were able to access care and treatment when they needed it.

The practice knew the needs of their patient population well. There was a holistic and pro-active approach to meeting patients' needs, which was driven by all staff. The services were flexible, and were planned and delivered in a way that met the needs of the local population, with involvement of other services.

We found that the staff team worked pro-actively with other local services, to improve the wellbeing of patients. For example, the practice had 218 patients with diabetes. The clinical staff worked closely with the local diabetes service; a specialist nurse provided advice and support to enable patients to be treated locally. The shared care approach enabled patients to receive holistic care and treatment at the practice.

The services were also delivered in a way to ensure continuity of care. For example, the lead GP carried out all home visits. He also visited the two main care homes each week to review patients who were registered with the practice. In between visits, he liaised with the care homes and reviewed patients as required.

Both health care assistants also had close links with one of the main care homes to aid communication. They assisted the lead GP on the weekly visits to the home they had links with, and followed up administrative duties from patient reviews. The pro-active approach provided continuity of care and ensured that patients were regularly reviewed, to help prevent unplanned admissions to hospital and health issues from becoming more serious.

We spoke with senior staff at two care homes where patients were registered with the practice, including the main care home the practice supported. They told us that the practice was generally very responsive to patients' needs.

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). For example, the practice's website had been changed to improve access to information for patients.

Tackling inequality and promoting equality

Staff told us they operated a patient list culture, accepting patients who lived within their practice boundary. The practice also provided temporary registration and treatment, where required.

Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

Staff were aware that advocacy services were available for patients who may require an advocate to support them. However, we did not see that patients had access to information about advocacy services on the practice website or at the surgery.

No patients expressed concerns about access to the premises. We noted that the premises and services had been adapted to meet the needs of people with disabilities, and maintain their independence. The practice was accessible to patients with mobility difficulties as facilities were all on one level. There was sufficient space for wheelchairs and pram access.

The practice had a 76% white British population; the other 24% were of mixed origin. Staff told us that most patients spoke English. They had access to a translation service and interpreters, where required. We saw that a translation service and information was available in various languages, for patients whose first language was not English.

Staff we spoke with said that they had attended recent equality and diversity training through e-learning. They also said that equality and diversity issues were discussed at team meetings. Records we looked at supported this.

Access to the service

Feedback from patients was continually positive about access to the service and appointments. They said that they had experienced no difficulties in making an appointment, with urgent appointments or telephone consultations available the same day. They also said that they did not have to wait long to be seen when attending the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The 2015 national GP patient survey information we reviewed showed patients responded positively to questions about access to appointments, and rated the practice highly in these areas. For example, the 2015 national GP patient survey showed that:

- 90% said that they found it easy to get through to the practice by phone, compared to the CCG average of 67% and national average of 73%.
- 84% were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 73%.
- 91% described their experience of making an appointment as good, compared to the CCG average of 73% and national average of 73%.
- 87 % said they usually waited 15 minutes or less after their appointment time, compared to the CCG average of 65% and national average of 65%.
- 82% of people were able to get an appointment to see or speak to a clinician the last time they tried, compared to the CCG and national average of 83%.

We found that patients were able to access appointments and services in a way and at a time to suit them. They were able to make an urgent appointment or request a telephone consultation the same day.

The appointment system was flexible; staff offered patients a choice of appointments where possible. Longer appointments were available, where required. Pre-bookable appointments were available four weeks in advance. Systems were in place to prioritise urgent and home visit appointments, or phone consultations for patients.

Access to the service and the opening hours enabled children and young people to attend appointments after school or college hours. It also enabled patients of working age and those unable to attend during the day, to attend early morning or an evening.

The practice was open between 8am and 6.30pm Monday, Tuesday and Friday. On Wednesday it was open from 8am until 1pm; after 1pm patients contacted the out-of-hours service via the NHS 111 telephone number. On Thursday it opened from 6.45am until 8pm to provide extended appointments and consultation times. Patients could also access daily telephone consultations and a 'drop in' service for minor health issues, where an appointment was not required between 8am and 9.30am.

Patients also had access to a walk in service on a Wednesday evening from 6.30pm to 8.30pm, and Saturday mornings from 9am to 12.30pm at a nearby Health Centre, which was run by local GPs. This enabled patients to see a local GP outside of the practice's opening hours.

In addition to providing the daily drop in service, the practice also had allocated time during the day when the lead GP was supernumerary to the appointment and consultation times. This enabled him to follow up patients with complex needs, liaise with relevant services, review test results and see or speak with patients who were booked in with a nurse or health care assistant, who required a GP opinion.

Four male GPs worked at the practice, three of which were locums. The practice also had three female nurses including two advanced nurse practitioners (ANP) who had recently joined the team. A couple of patients commented that the appointment of the female ANP's had enabled them more choice to see a male or female clinician.

Discussions with staff and records showed that the appointment system and telephone response times were regularly reviewed, to ensure that the practice responded to patients' needs.

Information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website. If patients called the practice when it was closed, an answer phone message gave the telephone number they should ring depending on the circumstances.

Listening and learning from concerns and complaints

Patients we spoke with said they felt listened to and were able to raise concerns about the practice. None of the patients had needed to make a complaint about the practice. A couple of patients were not aware of the process to follow should they wish to make a complaint.

We noted that information was available to patients to help them to understand the complaints procedure on the practice's website and at the surgery. However, the practice's complaints procedure and information available to patients, did not state that patients could direct their complaint to NHS England area team rather than the practice, in addition to contacting the Parliamentary Health

Good

Are services responsive to people's needs?

(for example, to feedback?)

Service Ombudsman to investigate second stage complaints. Following the inspection, the practice manager updated the complaints procedure and information available to patients to include the above.

A system was in place for managing complaints and concerns. The practice manager was the nominated person for handling all complaints. Staff told us where possible; concerns were dealt with on an informal basis and promptly resolved. We saw evidence of this.

The complaints log showed that the practice had received five complaints in the last 12 months. This recorded what each complaint related to, which helped the practice manager to consider any trends and patterns. Records we looked at showed that complaints had been acknowledged, investigated and responded to in line with the practice's policy, in a timely and open way. We noted that written responses to patients, did not advise people who they could refer their complaint to, if they were unhappy with how it had been investigated, or it had not been resolved to their satisfaction. The practice manager agreed to include this information in future responses.

Records showed that an annual meeting was held to review all complaints and significant events. This showed that appropriate learning and improvements had taken place, to improve the safety and quality of care for patients.

Are services well-led?

Good

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

Our findings

Vision and strategy

The aims and objectives set out in the provider's statement of purpose were to understand and exceed patients' expectations and to provide high quality personal care. Staff we spoke with knew and understood the aims of the service, and what their responsibilities were in relation to these. They were clear that they placed patients' best interests at the centre of everything they did.

The vision and future plans for the practice were not formally set out in the form of a business plan. However, senior managers were clear as to the short and long term plans for the service, and were able to demonstrate a commitment to on-going improvements.

Governance arrangements

The provider had various policies and procedures in place to govern the practice. A system was in place to ensure that the policies were regularly reviewed and were up-to-date, and shared with staff. Eight key policies we looked at had been reviewed recently and were up to date. We found that the policies were followed in practice.

Overall, we found that effective systems were in place for gathering and reviewing information about the quality and safety of services that people received. However, we highlighted areas where the systems for monitoring the services required strengthening, such as recruitment procedures and checks to ensure the defibrillator was working.

The practice had a system in place for completing clinical audit cycles, which it used to monitor the quality of care and services patients received. Systems were also in place for identifying, recording and managing risks. Various risk assessments had been completed; where risks were identified action plans had been implemented to minimise the risks.

Records showed that various meetings took place to aid communication and the sharing of essential information. For example, clinical meetings were held every eight weeks to share knowledge and learning between the GPs and nurses. General meetings involving all staff were held at three monthly intervals.

The practice had a small management team. The GP provider and the practice manager told us that they regularly reviewed the practice's business, finances, governance, performance and future plans. However, records were not kept to evidence this.

Leadership, openness and transparency

The practice had a clear leadership structure, which had been strengthened following the recent appointment of two nurse practitioners.

The findings of this inspection showed that the senior management team had the necessary experience, knowledge and skills to lead the team effectively. There was effective teamwork and a commitment to improving patient experiences. The culture and leadership empowered staff to carry out lead roles and innovative ways of working to meet patients' needs, and to drive continuous improvements.

Staff had lead roles and responsibilities to ensure that the service was well managed. There were high levels of staff satisfaction and engagement. Staff we spoke with were clear about their own roles and responsibilities, and felt that the practice was well led. They also said that they felt valued, well supported, and involved in decisions about the practice.

Staff described the culture of the practice as open and supportive, and felt able to raise any issues with senior managers as they were approachable and listened. The practice manager had an 'open door' policy to discuss any concerns or suggestions. A whistleblowing policy was in place. Staff we spoke with were aware of this, but they had not had cause to use it.

Records showed that regular team meetings were held, which enabled staff to share information and to raise any issues.

Seeking and acting on feedback from patients, public and staff

All patients we received feedback from praised the services they received. Several patients referred to the service and staff team as excellent and first rate.

There were high levels of engagement with patients. The practice actively obtained feedback from patients in a variety of ways, including complaints, surveys and the family and friends test. The results and actions agreed from

Are services well-led?

Good

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

the 2015 satisfaction survey were available at the practice and on the web site. The feedback was also shared on displays in the waiting room and in the newsletters. The survey results showed high levels of satisfaction, providing assurances that patients views were obtained, and their feedback was acted on to improve the service.

The practice and the Patient Participation Group (PPG) had put a joint action plan in place to address the key priorities agreed from the annual survey results.

The practice had an active PPG, which included representatives from various population groups, who worked with staff to improve the quality of care and services for patients. We spoke with two members of the PPG. They told us that the practice valued their role, and acted on their views. They were actively involved in the planning and delivery of services, and worked in partnership with the practice to improve the service.

The PPG were involved in various activities with involvement of the practice including:

- Educating patients who missed appointments as to the impact on others and the costs involved.
- Issuing of a regular newsletter, copies of which were displayed in reception, on the practice website, in local libraries and community centres. Housebound patients were also sent a copy.

The practice had also implemented various suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG, for example the website had been changed to improve access to information for patients.

The practice and the PPG held a diabetes health awareness event in 2013. They planned to provide a further event covering a different focus.

Records showed that the practice obtained feedback from staff through team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the service to improve outcomes for patients and staff.

Management lead through learning and improvement

There was a commitment to learning and the development of staffs' skills to ensure high quality care. Staff told us that they were actively supported to acquire new skills and further develop their knowledge to improve the services.

Discussions with staff and records showed that staff received continuous learning, training and an annual appraisal to develop their roles and improve outcomes for patients. The practice had a motivated and experienced staff team to enable them to deliver well-led services.

Records showed that appropriate learning and improvements had taken place and shared with staff, in regards to incidents, significant events and complaints to minimise further occurrences and improve the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way by ensuring that all staff have the qualifications, competence, skills and experience to do so safely. Regulation 12 (2) (c).