

Dr Sankarakumaran Sathanandan

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Sankarakumaran Sathanandan on 08 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed with all staff undertaking recruitment checks.

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

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

Summary of findings

- Where action plans have been put in place following the analysis of a significant event, undertake a review to ensure that the learning has been effective and maintained.
- Ensure staff undertaking chaperone duties are appropriately trained and have undertaken a disclosure and barring service checks.
- Ensure the practice daily cleaning records accurately reflect cleaning which has occurred.
- Ensure the risk of legionella is appropriately managed
- Ensure information is available to patients on the complaints procedure and that investigations and actions taken in response are fully documented.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement. However, we found reviews were not conducted following incidents to ensure learning had been embedded into practice. The practice was visibly clean and information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed but not all staff who undertook chaperone training had been appropriately security checked. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

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

Good



Summary of findings

facilities and was well equipped to treat patients and meet their needs. However, we found information about how to complain was not readily available and whilst the practice had investigated and responded to concerns these were not always sufficiently documented.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and supportive of the practice and their staff. Staff had received inductions, regular performance reviews and attended staff meetings.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered personalised care to meet the needs of the older people in its population. They provided phlebotomy services (obtaining blood) and patients who were identified as vulnerable received monthly reviews. It was responsive to the needs of older people, and conducted home visits to identify emerging patient needs and provided rapid access appointments for those with enhanced needs.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The clinical team worked closely in the management of specific conditions such as chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the lead GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered a range of specialist clinics, child health clinics, antenatal and postnatal clinics. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered well man and women clinics and was proactive in offering online services and evening telephone consultations. They also offered a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The GP personally contacted all patients inviting them to attend their reviews. The practice found this significantly improved attendance rates and enabled them to provide a better and more individualised service to meet their patient's needs. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health. The GP personally contacted all patients inviting them to attend their reviews and found this significantly improved attendance rates and enabled them to provide a better and more individualised service to meet their patients' needs. People experiencing poor mental health had received an annual physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisation. The practice also worked closely with specialist mental health providers to manage emerging risks to patient safety and followed up with patients and their consultants to ensure they were appropriately supported.

Good



Summary of findings

What people who use the service say

We gathered the views of patients from the practice by reviewing data available from NHS Choices and the National GP Patient Survey results from 2015. Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution among patients in order to obtain their views about the practice and the service they received.

We reviewed the findings of the National GP Patient Survey 2015 for which there were 112 responses from the 259 questionnaires distributed to patients, a response rate of 43% of those people contacted. The practice performed above the national and CCG averages with 89% of respondents said they would recommend this practice to someone new to the area. 93% of respondents described their overall experience of this practice as good and 84% of respondents were satisfied with the surgery's opening hours. The practice performed below the Clinical Commissioning Group average and national averages for; respondents with a preferred GP usually getting to see or speak to that GP and for respondents usually waiting 15 minutes or less after their appointment time to be seen.

We reviewed patient comments on the NHS choices website. We found one review had been made within the

last 14 months. This rated the practice highly although did make reference to difficulties sometimes obtaining an appointment with the lead GP as opposed to the locum doctors. The practice told us that they had appointed locum GPs to provide continuity of care to patients.

We received 43 completed 'Tell us about your care' comment cards. These were overwhelmingly positive about the service patients received from the clinical and administrative team. Patients commented on the caring nature of staff and the ease at which the GP accommodated their requests for appointments and home visits. They had confidence in the professionalism and commitment of the staff to meet their health and welfare needs.

We spoke with six patients, including two members of the Patient Participation Group. They all told us that staff were polite and helpful. The patients had been with the practice for a number of years and respected and valued the service they received from the nurse and GPs. They told us that the GPs were kind, personable and consistently showed them patience and support.

Areas for improvement

Action the service **SHOULD** take to improve

- Where action plans have been put in place following the analysis of a significant event, undertake a review to ensure that the learning has been effective and maintained.
- Ensure staff undertaking chaperone duties are appropriately trained and have undertaken a disclosure and barring service checks.
- Ensure the practice daily cleaning records accurately reflect cleaning which has occurred.
- Ensure the risk of legionella is appropriately managed
- Ensure information is available to patients on the complaints procedure and that investigations and actions taken in response are fully documented.

Dr Sankarakumaran Sathanandan

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Sankarakumaran Sathanandan

Dr Sankarakumaran Sathanandan practice has a patient population of 3441. The practice is managed by a single GP who holds financial and managerial responsibility for the practice. The practice has a lead GP and two locum GPs, a female and male locum who work two days each week on a Monday and Friday and a Tuesday and Thursday. They also employ a part time practice nurse. There are six receptionists and a practice manager who retains her professional registration as a nurse and provides limited clinical interventions.

The practice holds a General Medical Services contract with NHS England who commissions the services.

The practice phone lines are open from 8am to 6.30pm Monday to Friday. Appointments with GPs are available between 9am to 11.30am Monday, Tuesday, Thursday and Friday and 9am and 11am on Wednesdays. On Monday, Tuesday and Friday afternoon appointments operate from 3.30pm to 6pm and on Wednesday 4pm to 6pm and Thursday 4pm to 6.30pm. Nurse appointments are

available three days a week, Monday 8.30am to 1pm and 2pm to 3pm, Wednesday 7.30am to 2pm and on Thursday 11am to 1pm and 2pm to 7pm. Late night GP appointments are offered on a Wednesday 6.30pm to 7.15pm and late night nurse appointments are available on a Thursday 6.30pm to 7pm. Patients may request telephone advice and speak to a GP or nurse designated times were stated on the practice website. Patients could phone to speak with a GP between 11.30am and 12.30. However, the times to speak with a nurse varied on the day with different times.

The practice maintains a comprehensive website that may be translated into 63 different languages. It provides a range of information relating to their services including details of the appointment system, staff, clinics provided, practice news and the practice contact details. It also details the practice mission statement to provide quality, caring, patient-centred healthcare and ensuring that each patient leaves their surgery feeling their concerns had been heard and questions answered and patients' rights to expect a high level of care.

The practice serves an ageing population with greater representation in patients over 65years. They also have a high number of patients with long standing health conditions.

The practice has opted out of providing out-of-hours services to their own patients. Patients are advised to call 111 when they require medical assistance that is not an emergency. NHS 111 is available 24 hours a day, 365 days a year. Patients are advised that casualties can be seen at all times at the Accident and Emergency Department at Southend General Hospital.

Detailed findings

Why we carried out this inspection

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

Comprehensive inspections are conducted 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?

- 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 that we hold about the practice. We asked the practice to provide details of other organisations to share what they knew. We carried out an announced visit on 08 July 2015. During our visit we spoke with a range of staff, GP, practice manager and receptionists and spoke with patients who used the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. They maintained a reference file with details of the types of incidents that should be reported and to who, such as the Reporting of Injuries Disease and Dangerous occurrences (RIDDOR). They also reviewed 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.

We spoke with staff and reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. For example, the GP told us how they reviewed patient records in response to a Medicines and Healthcare products Regulatory Agency (MHRA) alert. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice. On receipt of such a notification relating to medicines the GP reviewed all patients' records to identify those who may have been adversely affected. All patients identified as potentially affected were personally called by the GP, who invited them to attend the practice facilitating appointments at their convenience for medication reviews. Their medication was reviewed in consultation with them and any changes explained to them. This showed the practice had an awareness and commitment to ensure the timely and appropriate actioning of information to provide safe patient care.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed five significant incidents reports, four related to difficulties with patient referrals. We tracked two incidents. The records were completed by either the practice manager or clinician as appropriate and included their investigation and action taken as a result. We reviewed practice meeting minutes for 2014 and 2015 and they showed that significant incidents had been discussed. We found where persons involved in the incidents were not present for the discussion of the investigation, outcome and learning; the minutes were shared with them later and

signed for by staff to show they had read them. However, where action plans had been produced we found no evidence of them being reviewed to assure themselves learning had been embedded into their work and they had sufficiently mitigated the risk of such an incident reoccurring. For example, we saw evidence of an incident that had occurred in 2014. The incident was discussed at the next practice meeting but the clinician involved was not present for the meeting and there was no evidence of who, when or where the issue had been discussed. The practice decided to audit to check a similar incident had not previously unknowingly occurred. This did not, however, mitigate the risk of a reoccurrence. We spoke with the lead GP who explained how they mitigated this potential reoccurrence through improved recording, and read coding the information.

National patient safety and medicines alerts were received by the practice manager who shared these with the clinical team. The practice manager conducted searches on the practice records to identify patients who may benefit from a review being conducted. This information was then given to the GP to consider and document action taken in response.

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 staff had received relevant role specific training on safeguarding for both vulnerable adults and children. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. We were told how they recognised potential vulnerability for example a patient who repeatedly made mistakes with their medication. This heightened concerns for the patient and resulted in a referral being made to the memory clinic where the patient was diagnosed with dementia and a care plan put in place. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns. They knew how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice lead GP led in all areas such as safeguarding vulnerable adults and children. They were able to

Are services safe?

demonstrate they had undertaken the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. For example, staff told us how they had raised concerns when they had noticed a child had come to the attention of a number of external agencies. They followed the safeguarding policy to formally raise their concern to identify potential risks to the child. The practice supported the member of staff raising the concerns and investigated the allegations. The practice confirmed appropriate agencies were involved with the care of the child.

There was a system to highlight vulnerable patients on the practice's electronic records. We found the practice was 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. The lead GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services to ensure their patient records were accurate.

There was a chaperone service, and the service was advertised on the practice website and within the main waiting area. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff and reception staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. However disclosure and barring service checks had not been undertaken on reception staff carrying out this role as a GP was always present. The practice told us they would discontinue reception staff being chaperones whilst they obtained DBS checks.

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 were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. However, we found that some of the needles and syringes for administering the medicines were out of date and no longer sterile and this posed a risk to patients. Whilst we found there were systems in place relating to the monitoring of medicines these were not clear and lacked sufficient detail to provide assurance. For example, we found records failed to show that medicines had been ordered to replace those due to expire imminently and not all medicines were stored where stated. The practice has since implemented a new stock control system recording expiry dates to mitigate the risk of a reoccurrence and disposed of out of date stock.

We found the practice worked well with the medicines management team and in line with medicines prescribing when compared with similar practices within their Clinical Commissioning Group. No patients reported experiencing difficulty obtaining their medicines.

The nurse administered vaccines using patient specific directions. These are written instructions from a qualified and registered prescriber. They describe the dose, method and frequency or appliance to be supplied or administered to a named patient. We saw up-to-date copies of both sets of directions and evidence that the nurse 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. We spoke with staff who knew which medicines were high risk and to check appropriate monitoring tests had been conducted, in the event these had not, they would notify the lead GP to action.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and the practice manager checked and audited the cleaning to maintain standards of cleaning. The practice

Are services safe?

acknowledged their daily cleaning records did not accurately reflect cleaning which had occurred. 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 control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff received training about infection control specific to their role and the practice manager followed up on those staff still to complete the training.

The practice conducted infection prevention control audits. These were general and not room specific and may benefit from being revised to ensure they are reflective of current practice and risk. For example, the practice had an infection and prevention control audit for risks associated with surgery but the practice no longer provided the clinical intervention. The audit also stated that a risk assessment/testing for legionella was not applicable. However we found a legionella risk table stating the actions the practice should take to manage the risk. The practice told us they did take some of the actions required for example the practice did run the taps in the rooms but did not monitor the temperatures of the water as required and record the checks. This is required to ensure the safety of the water supply. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Designated staff were required to clean anybody spillages and specific materials were available for this purpose. All staff had been offered the Hepatitis B injection to mitigate the risks of blood borne infections; all clinical staff had been vaccinated.

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.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was in place. We saw evidence of the annual calibration of relevant equipment; for example weighing scales, spirometers, ECG, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to people commencing their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. However, we found the practice had introduced disclosure and barring service checks for all clinical staff and obtained references prior to allowing them to practice independently.

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. 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.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

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 did not include access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to

Are services safe?

attempt to restore a normal heart rhythm). National guidance and national standards in place at the time of our inspection stated practices should be encouraged to have defibrillators. The National Resuscitation Council states current resuscitation guidelines emphasise the use of oxygen, and this should be available whenever possible. Oxygen is considered essential in dealing with certain medical emergencies (such as acute exacerbation of asthma and other causes of hypoxemia). The practice had assessed the risk to patient safety for not having oxygen or a defibrillator available. They considered it was not necessary due to the close proximity of Southend General Hospital and staff knew to call the emergency services.

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 and anaphylaxis. 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. Risks had been identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of premises and difficulties accessing the building. The document also

contained relevant contact details for staff to refer to. For example, contact details of utility companies and the alternative site details. The document was not dated and the information and contact details for providers may benefit from being revised to ensure all appropriate details were accurate.

The practice had carried out a fire risk assessment on 10 December 2014. The practice was also visited by Essex Fire and Rescue Service in March 2015 who found the practice fire safety procedures to be satisfactory. Portable appliance testing had been conducted on electrical equipment and was next scheduled for inspection February 2016. Records showed that staff undertook eLearning fire training.

A building security risk assessment was conducted in April 2015 as was a risk assessment table which identified the likelihood of an occurrence, likelihood of severity and mitigation measures in respect of identified risks such as slips, trips and falls, hand injuries, manual handling and risk of infection. However, both documents would benefit from being revised as some of the assessment was incomplete and therefore the full risks may not have been appropriately assessed in relation to the threats presented. For example; the risks associated with staffing changes (both planned and unplanned) would benefit from being included on the practice risk log.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP 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. Staff told us they received regular professional guidance updates via their email system and the lead GP told us of weekly clinical meetings held with the team each Friday to discuss clinical cases, safeguarding concerns and medical developments. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and where patients were discussed and actions agreed and assigned.

We found the clinical team were using clinical templates to promote consistency and these were reviewed when appropriate. The GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The lead GP showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing. The practice prescribing rate was below similar practices in the local area. The practice achieved this whilst caring and meeting the need of older people and those with long term conditions who may be more vulnerable to contracting viral infections. The practice also told us of how they ensured patients were receiving effective care. The GP had completed a review of case notes for patients with high blood pressure which showed all their patients were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were also shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

National data showed that the practice was in line with GP practices locally for referrals made to secondary and other community care services for all conditions. The GP we spoke with and the records we reviewed showed the

practice used national standards for the referral of suspected cancers. They also conducted an ongoing audit of all referrals to ensure they were timely and patients were able to access care appropriately.

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

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. For example, the reception team were aware of patients on certain disease modifying medicines that required regular blood tests to ensure their health needs were appropriately responded to. Where reviews had not occurred this was brought to the attention of the GPs.

The practice showed us three clinical audits that had been undertaken in the last year. There was evidence of completed audit cycles where appropriate and we were able to demonstrate the changes as a result.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics. The practice had chosen this audit as it had previously been highlighted as an area for development during the previous year's prescribing audits. The audit looked at the prescribing of the practice to ensure they were practicing in accordance with the local area agreements. The audit found that where they had to follow some of the CCG guidelines this had been ineffective to meet the needs of their patients and they had had to repeat prescribe medicines to the patient. They had discussed this with the CCG to ensure the CCG advocated the most effective treatment for patients. The practice intended to conduct a secondary audit within the next 12 months for completeness.

Are services effective?

(for example, treatment is effective)

We reviewed a completed audit cycle on sleeping medicines. The purpose of the audit was to reduce patient's dependency on them and to provide them with alternative medicines. The audit showed that on reviewing patient's medicines they had reduced 70% of their prescribing of the medicine. This had been achieved by supporting and educating the patients on the risks and either by stopping prescribing or changing the patient's medicine.

The practice had conducted 12 prescribing audits and two clinical audits in the last 12 months. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed consistently well and the GP personally invited patients to attend reviews. The lead GP told us they found patients were more responsive to a personal request for their attendance and patients spoke highly of the personalised care they received from the GP and practice. The practice was not an outlier for any QOF or other national clinical targets.

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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register. Six weekly palliative care meetings were held with the Macmillan nursing team whereby they also reviewed the patient's treatment preferences in relation to resuscitation, preferred place of care, lasting power of attorney and capacity issues. We found that patients on the practice fragility register, some of whom had complex needs and were house-bound and elderly, received appropriate care and treatment. They were visited routinely to review their health and were not dependent on them contacting the practice and requesting an appointment enabling the surgery to provide a responsive and caring individualised service.

The practice also participated in local benchmarking run 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. For example, the practice performing similar to other practices locally for ensuring that patients who were eligible such as those over 65 years had received a flu vaccine within the previous 12 months. The practice also performed well compared to GP practices nationally for assessing and monitoring patients with certain long term conditions such as diabetes, cardiac conditions and patients with mental health conditions. 100% of the practices' patients with mental health conditions had a comprehensive and agreed care plan. 100% of patients who were diagnosed with dementia had a face-to-face review within the previous 12 months. Similarly the percentage of patients who had diabetes who had been reviewed and their blood pressure, blood glucose and creatinine: albumin ratio monitored were in line with or higher than the national averages. These checks help to identify conditions associated with diabetes including heart disease, high blood pressure and kidney disease.

Effective staffing

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

Staff undertook annual appraisals that identified learning needs from which action plans were documented, with the exception of the practice manager. This was acknowledged by the lead GP who agreed to action this. The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. The GP oversaw the practice nurse appraisal to ensure they had completed all required training elements such as the administration of vaccines, cervical cytology, smoking cessation, vaccinations NHS health checks. The

Are services effective?

(for example, treatment is effective)

lead GP told us daily clinical discussions were held with clinicians but these were not formally minuted or consistently recorded within the patient notes. The practice had identified that the training and development of their staff was an area for improvement especially in relation to their non-clinical team, who told us they had little or no protected time to undertake their e-learning.

The practice manager told us they had no reported issues with staff performance. However, in the event this may occur, the practice manager would provide the staff member with support, additional training and mentoring opportunities prior to initiating poor performance procedures.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The 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 reviewed 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. The lead GP and the practice manager also checked daily to ensure all test results were actioned.

The practice reviewed all discharged patients and all accident and emergency attendances and admissions and contacted patients where appropriate. This involved making home visits to some of their patients.

The practice held multidisciplinary team meetings six weekly to discuss the needs of patients with complex needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely

manner. Electronic systems were also in place for making referrals. Staff reported that this system was easy to use. Referrals were audited by the practice manager to ensure they were actioned in a timely manner. Staff would contact patients to ensure they had received appointment dates. Where these had not been received, staff would follow up with the appropriate partner agency to ensure the patient received their appointment. For example, delays had been experienced by patients requiring the use of a specialist community health service. The specialist team were unable to access the shared electronic patient record system to see referrals and update information. Once the delay was identified the practice put systems in place to follow up with the specialist service and patients to ensure they were accessing the services in a timely and appropriate way.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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. The GP told us of how they assessed a patient's capacity, made best interest's decisions for patients and supported patients to make decisions through the use of care plans, which they were involved in agreeing. The patient care plans were reviewed annually or more frequently, if required.

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).

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the

Are services effective?

(for example, treatment is effective)

practice. The lead GP saw all children newly registered with the practice and personally summarised all new patients' medical records to be confident their medical needs were fully known and met by the practice.

The lead GP told us how he checked the practices records were accurate for patients whose circumstances may make them vulnerable. The GP checked their practice patient list for people with learning disabilities against the social services list of people with learning disabilities to ensure they had correctly identified patients with such a need. The GP personally contacted each of his patients with learning disabilities to invite them to their annual health checks and offered them an hour long appointment. The GP told us patients were more receptive to attending when personally invited and they felt they could provide a better service to them.

We noted a culture among the clinical team 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 under 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, conducted by the nurse.

The practice's performance for the cervical screening programme was 94.52%, which was above the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend.

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

- Flu vaccination rates for the over 65s were 62.07%, and at risk groups 73.24.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 80% to 100% and five year olds from 89.3% to 96.4%.

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 GP Patient Survey 2015 and Care Quality Commission comment cards completed by patients.

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 GP Patient Survey 2015 showed that patient experiences were similar or slightly higher than the CCG or national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 91% of respondents said the GP was good at listening to them, which was above the CCG average of 84% and national average of 89%.
- 89% of respondents said the GP gave them enough time, which was above the CCG average of 84% and the national average of 87%.
- 94% of respondents said they had confidence and trust in the last GP they saw, which was the same as the CCG average of 94% and just below the national average of 95%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and 32 of the cards were overwhelmingly positive about the service and staff. Patients said they felt the practice offered a highly personalised and committed service and staff overall were efficient, helpful and caring. They said staff treated them with dignity and respect.

This was reflected in our discussions with representatives from the Patient Participation Group (PPG) and in our conversations with patients on the day of our inspection. The practice PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The two less positive patient comments related to inconsistent medical advice relating to children's specialist health provision and the opportunity to discuss multiple health concerns during an appointment. The lead GP acknowledged that prior to the appointment of the current clinicians some patients had reported disparities in care. The PPG and the practice believed the appointment of a permanent clinical team assured patients they would receive continuity of care.

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 rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to observe the practice patient confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by screens which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

The practice had a working relationship with support services to ensure people whose circumstances may make them vulnerable had access to the practice without fear of stigma or prejudice. Staff were committed to ensure patients were treated sensitively and individual needs met. There were signs throughout the practice for the information of patients and these were also printed in braille to assist blind patients and those with visual impairments.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey 2015 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:

- 85% said the last GP they saw was good at explaining tests and treatments this was slightly higher than the CCG average of 84% but below the national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care. This was higher than the CCG average of 78% and national average of 81%.

Are services caring?

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and it was also highlighted on the practice website.

Patient/carer support to cope emotionally with care and treatment

The National GP Patient Survey 2015 information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 87% said the last GP they spoke to was good at treating them with care and concern, above the CCG average of 82% and the national average of 85%.
- 94% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these

highlighted that staff responded compassionately when they needed help and provided support when required. They also reported the lead GP had a wealth of personal knowledge relating to the patients and great empathy and professionalism in meeting their individual needs and often those of their family. We were told the GP was accessible and compassionate and highly committed in researching and securing personalised care plans to meet patient's immediate and emerging needs.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. Patients who were carers were identified at point of registering with the practice and were added to the practice's computer system alerting the GPs. The practice provided patients who were carers with leaflets regarding contacts that may be helpful to carers. When a carer contacted the practice for an appointment for themselves or others the practice tried to best accommodate their needs, such as providing convenient appointment times. The lead GP reserved time each week for patients who may benefit from specific protected clinical time for their individual needs such as those with caring responsibilities and people who experienced poor mental health.

The practice had a system in place to deal with bereavement. The GP told us, they would speak with the family at a convenient time and offer them support and information about external agencies that could provide support. Every bereaved family was sent a sympathy card from staff at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The 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.

The practice worked well with the Patient Participation Group that had increased significantly in membership due to growing interest. They took an active involvement in educating patients regarding the services available at the practice and encouraging and facilitating seasonal vaccination programmes. This was in addition to discussing patient concerns raised with the PPG Chairperson and implementing suggestions for improvements such as changes to the internal layout of the waiting area, covering the fireplace and the plug sockets for the safety of children.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice was located within a converted bungalow. The practice had adapted the building to improve access for their patients with limited mobility or with pushchairs and prams. There was ramp access to the practice via the main entrance and an automatic entrance door. The reception, waiting area and clinical rooms were situated on the ground floor and administrative offices were located on the first floor. The practice was restricted by the design of the building resulting in a number of doors to open depending on which clinical room visited and narrow hallways. However, staff were mindful of this and told us how they helped patients who may experience difficulties. We also

saw staff assisting patients on the day, by holding doors open and activating the entrance doors. Accessible toilet facilities were available for all patients attending the practice and these included baby changing facilities.

Access to the service

The practice phone lines were open from 8am to 6.30pm Monday to Friday. Appointments with GPs were available between 9am to 11.30am Monday, Tuesday, Thursday and Friday and 11am on Wednesdays. On Monday, Tuesday and Friday afternoon appointments operate from 3.30pm to 6pm and on Wednesday 4pm to 6pm and Thursday 4pm to 6.30pm. Nurse appointments were available three days a week, Monday 8.30am to 1pm and 2pm to 3pm, Wednesday 7.30am to 2pm and on Thursday 11am to 1pm and 2pm to 7pm. Late night GP appointments were offered on a Wednesday 6.30pm to 7.15pm and late night nurse appointments were available on a Thursday 6.30pm to 7pm. Patients may request telephone advice and speak to a GP or nurse designated times were stated on the practice website. Patients could phone to speak with a GP between 11.30am to 12.30. However, the times to speak with a nurse varied on the day with different times.

On the day of our inspection we found patients had a two week wait to book an appointment with their preferred GP in advance but 'on the day' and urgent appointments were available. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. 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.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. On the day of our visit we saw the GP respond to an urgent appointment was presenting with potential serious medical concerns.

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided text message reminders for appointments and online booking services which a patient commented on as being a good service. People whose circumstances may make them vulnerable were offered long appointments and were personally invited to attend the practice by the GP. The GP would discuss and try to best facilitate their individual needs such as providing appointments at quieter times for people who may find attendance stressful. Home visits were made where needed and priority appointments were given to children.

The practice had a zero tolerance policy to protect patients and staff from unacceptable behaviour. We saw where patients were aggressive and/or inappropriate towards staff and patients, that staff reported their concerns. For example, where a patients' behaviour was unacceptable, the practice took appropriate action to remedy the situation and if necessary, remove the patient from the practice list after following the recommended procedure and consulting with the CCG.

Listening and learning from concerns and complaints

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

We saw that information was not available to help patients understand the complaints system and complaints forms

were not in use. However, staff told us and the practice manager confirmed that complaints leaflets may be printed by staff on request. We reviewed the leaflet and found it contained relevant information and included how patients could refer the matter to the Health Ombudsman if they were not satisfied with the outcome. However, staff told us all concerns were automatically reported to the practice manager who would try and resolve the issue immediately. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found not all had sufficient records to show the practice had adequately responded to the patient's concerns. For example, we found the response to one complaint that the complainant was contacted by telephone and was happy with the outcome. We found that where appropriate complaints were escalated to the Health Ombudsman for oversight or shared with the practices, the commissioners and NHS England. However, where concerns had been raised in respect of the practice's responsiveness to a patients care we saw no records to demonstrate staff had reflected on their clinical actions. However, staff told us they reviewed the initial response sent by the practice to the complainant and amended this to reflect their position. The practice did review complaints to detect themes or trends and ensured that lessons learned from individual complaints had been acted on.

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 mission statement to provide quality, caring, patient-centred healthcare. They strived to provide an efficient, courteous customer service to the best of their abilities whereby they developed mutually fulfilling doctor-patient relationships based on open communication. We spoke with the Patient Participation Group who felt that the practice consistently achieved this and this was reflected in their National GP Patient Survey. The practice had consistently positive patient feedback especially in respect of the NHS Friends and Family Test (FFT) where they have been identified as a champion surgery for implementing the FFT. The NHS friends and family test is an important opportunity for patients to provide feedback on the services that provide their care and treatment. Champion surgeries are invited to share their success with other practices and hospitals to enhance understanding of the FFT and to promote excellence.

We spoke with members of staff and they all knew and understood the vision and values. They told us they believed the practice should be caring and responsive to the patient's individual needs. All staff knew what their responsibilities were in relation to these.

We reviewed the practice five year business plan. It outlined changes to their contract and the financial implications on the business from 2014 to 2019. They identified potential cost savings and revenue streams such as their practice capacity for increasing patient numbers and the additional measures necessary to maintain a safe, effective and accessible service. They proposed means of assessing impact of decisions through conducting audits and surveying patient experiences in partnership with their Patient Participation Group.

The practice told us of the constant challenges in attracting, appointing and retaining good clinical staff. They had tried to secure a permanent partner or salaried GP for the practice but had been unsuccessful in recruiting one. However, the lead GP had employed both GPs on GP locum contracts affording them employment rights and entitlements. The GP discussed both business and clinical decisions with colleagues and valued their contributions.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of the practice's policies and procedures. Staff were invited to sign a record stating they had read them but it failed to specify which policies. This was acknowledged as an area for development by the practice.

There was a clear structure with named members of staff having responsibilities for specific roles. Although, due to the small staff team, the practice hoped to train staff in performing others' roles to build resilience into the team. For example, the practice manager had maintained her professional registration as a nurse and was able to perform certain clinical interventions to assist in the absence of the practice nurse. We spoke with members of staff and they were all clear about their own roles and responsibilities and those of others. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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 between the lead GP and the practice manager each week.

The practice had an ongoing programme of prescribing and clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice conducted audits on their two week referrals for osteoporosis, accident and emergency attendances and prescribing audits for antibiotics over the winter period. The practice identified where they had performed well such as being a low prescribing practice but also where changes were proposed, learning was shared.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. The practice manager and the lead GP told us how they met weekly to discuss the management of the practice including where risks to providing a safe and effective service had been identified and produced action plans and implemented them.

Leadership, openness and transparency

Are services well-led?

Good 

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

Staff told us and we saw that team meetings were held regularly. 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 was responsible for human resource policies and procedures. We reviewed a number of policies for example, the practice recruitment policy, induction policy and complaints management which were in place. We looked at four personnel records for staff that had joined the practice within the last 18 months. We found staff had received an induction; this was comprehensive and showed they had obtained the relevant standards to perform their role competently.

We found that the practice investigated and responded to significant incidents. However where external failings were identified we found no evidence to demonstrate the practice had escalated these to the external body to ensure they were investigated internally, lessons learnt to mitigate a reoccurrence and risks minimised to patient safety.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received). We looked at the results of the last patient participation survey report 2014. The PPG had decided that their survey would reflect issues that patients had identified such as; the appointment system, communication with the practice, overall satisfaction with their clinicians and their general experience of the practice. A total of 150 surveys were handed out to patients by the reception staff over a two week period between September and October 2014. Their findings showed that 80% of the patients who responded rated their satisfaction with the appointment system as good, very good or excellent and 96% of patients rated the practice good, very good or excellent. Comments made by patients were also considered in partnership with the PPG. The practice had developed an action plan in response to their findings and reviewed it with the PPG at their meetings to monitor progress.

The practice had an active patient participation group (PPG) consisting of 56 patients. The PPG included representatives from various population groups such as older people, working aged people and those with long term conditions. The PPG met every quarter, attendance varied with some members just choosing to receive

information via email or post. The PPG Chairperson met weekly or as required with the practice manager to discuss a range of patient issues including changes to staffing. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results of the 2014 Patient Participation Survey were available on the practice website as was the monthly patient newsletter regarding practice achievements and forthcoming events.

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

The practice had a whistleblowing policy which was available to staff and all policies were accessible on any computer within the practice. Staff were invited to sign to state they had read and understood the policies.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training but non-clinical staff told us that they had limited protected time to undertake their e learning. This was acknowledged by the practice manager who told us that they would personally speak with staff in the future to promote understanding of issues.

We spoke with the GP who told us of how they maintained their professional knowledge and skills. They were engaged with a single practitioner group consisting of 15 single handed local GPs who met once a month in the evening to invite a consultant to talk about a clinical topic. The GP also participated in a peer review system held once a month in the evening where they discussed difficult cases and scenarios. They anonymised the cases and wrote to two consultants for their professional opinions. The outcome of their clinical enquiries was then discussed in a safe learning environment. These meetings were well attended and valued by the GP who attended in addition to monthly time to learn training sessions provided by the Clinical Commissioning Group.

Are services well-led?

Good 

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

The practice had completed reviews of significant events and other incidents. However, the absence of staff involved in the incidents, at the clinical discussion, may be considered a lost opportunity for feedback and learning.