Dr Dinah Roy

Quality Report

Oxford Road Medical Centre,
Oxford Rd,
Spennymoor,
DL16 6BQ
Tel: 01388 810081
Website: www.oxfordroadsurgeryspennymoor.nhs.uk

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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 this comprehensive inspection on 22 September 2015.

Overall, we rated this practice as good. Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services.

Our key findings 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.
- There were systems in place to reduce risks to patient safety for example, infection control procedures.
- 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.

There were some areas of practice where the provider needs to make improvements.

The provider should:

- Ensure the practice information leaflet is available in reception when patients ask.
- Ensure that stock control and date check systems function correctly so that all single use clinical instruments stored and used are within their expiry dates. Dispose of in accordance with the appropriate guidance any unused instruments or equipment which have expired.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed, although not all risks to patients were identified and assessed. There were sufficient numbers of staff with an appropriate skill mix to keep patients safe. Appropriate recruitment checks had been carried out on staff.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. 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 for all staff. Clinical staff undertook a range of audits of care and reflected on patient outcomes. The practice worked with other services on a multi-disciplinary basis and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was positive. We saw that staff treated patients with kindness and respect and maintained confidentiality. In patient surveys, the practice scores were around average compared to local and national survey results. Patients said they were treated with care and concern.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with the CCG to secure service improvements where these had been identified.

Patients told us they could generally access appointments, although we did receive some negative feedback about how easy it was to access a named GP. Urgent appointments were available on the same day. The practice had sufficient facilities and equipment to

Summary of findings

treat patients and meet their needs. Information about how to complain was available, although patients had to request this as the practice leaflet was not made available in reception. The practice responded appropriately when issues were raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Governance arrangements were underpinned by a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity. 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, although currently had no active Patient Participation Group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice was aware of future challenges and was working towards meeting these.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population, offered home visits and urgent appointments for those with enhanced needs. It was responsive to the needs of older people and patients over 75 had a named GP. Emergency admissions to hospital were discussed and reviewed at regular multidisciplinary clinical forums.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes attended regular nurse clinics to ensure their conditions were monitored and were involved in making decisions about their care. Nurses communicated with GPs for each condition.

The practice had introduced an annual health review and patient held plan for those with long-term conditions; which aimed to provide a holistic approach to patient's care and increased patient involvement.

Families, children and young people

Good

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. Immunisation rates were good for all standard childhood immunisations. Weekly child health clinics were held jointly by the practice nurse and health visitors. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Young people could access sexual health screening services and contraception advice.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working population had been identified and services adjusted and reviewed accordingly. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. Telephone appointments were available. The practice carried out health checks for people of working age, and actively promoted screening programmes such as for cervical and bowel cancer. Patients could access the weekly physiotherapist service based at the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. Patients or their carers were able to request longer appointments if needed. The practice had a register for looked after or otherwise vulnerable children and also discussed any cases where there was potential risk or where people may become vulnerable. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns.

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 carried out opportunistic screening for dementia. The practice sign-posted patients experiencing poor mental health to various support groups and voluntary organisations as required. Patients could also access a practice-based counselling service. For some patients with complex needs, multi-disciplinary meetings were held on a case-by-case basis at the practice with Consultant psychiatrists and other Mental Health Team clinicians.

Summary of findings

What people who use the service say

The latest NHS England GP Patient Survey of 98 responses showed the following:

What this practice does best

96% of respondents say the last nurse they saw or spoke to was good at treating them with care and concern

Local (CCG) average: 94% National average: 90%

94% of respondents say the last nurse they saw or spoke to was good at explaining tests and treatments

Local (CCG) average: 93% National average: 90%

70% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: 70% National average: 65%

What this practice could improve

68% of respondents are satisfied with the surgery's opening hours

Local (CCG) average: 81% National average: 75%

71% of respondents would recommend this surgery to someone new to the area

Local (CCG) average: 83% National average: 78%

81% of respondents describe their overall experience of this surgery as good

Local (CCG) average: 91% National average: 85%

84% say the last GP they saw or spoke to was good at listening to them

Local (CCG) average: 91%, National average 89%

79% say the last GP they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average 86%, national 82%

We spoke to six patients as part of the inspection. We also collected 41 Care Quality Commission (CQC) comment cards which were sent to the practice before the inspection, for patients to complete.

The majority of patients we spoke to and the comment cards indicated patients were highly satisfied with the service provided. Patients said they were treated with dignity and respect and that staff were professional, friendly and caring. Patients said that their needs were responded to and they received the care that they needed. Patients said they were treated as individuals and involved in their care. Of the negative feedback we received, the most common complaint was difficulty getting an appointment with a named GP.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the practice information leaflet is available in reception when patients ask.
- Ensure that stock control and date check systems function correctly so that all single use clinical instruments stored and used are within their expiry dates. Dispose of in accordance with the appropriate guidance any unused instruments or equipment which have expired.

Dr Dinah Roy

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 specialist advisor GP.

Background to Dr Dinah Roy

Dr Dinah Roy is a sole GP, also supported by another salaried GP and a locum. The practice provides personal medical services (PMS) to approximately 2,700 patients in the catchment area of Spennymoor, which is the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG) area.

There are two practice nurses and a healthcare assistant. These are supported by a practice manager and a team of reception and administrative staff. The practice is a training practice and was supporting a GP registrar at the time of inspection.

The practice is open between 8.30am and 6pm Monday to Friday, with actual consulting times between 9.00am-11.45am and 2:30pm-5:30pm.

The practice has higher levels of deprivation compared to the England average and higher levels of people with caring responsibilities or claiming disability living allowance. The practice has opted out of providing Out of Hours services, which patients access via the 111 service. The practice is a member of the South Durham Health CIC Federation, a collaborative of 24 GP practices in County Durham.

Why we carried out this inspection

We carried out the inspection 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.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia).

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection.

We carried out an announced inspection on 22 September 2015.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with management staff, GPs, nursing staff, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hours' team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. People affected by significant events received a timely apology and were told about actions taken to improve care. Staff told us they would inform the practice manager or relevant clinical lead of any incidents and there was also a recording form available on the practice's computer system. There was a culture that anyone could raise any incident, and the practice manager would then decide which incidents needed to be discussed at a weekly clinical forum, staff meeting, or reported externally.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice, either through sharing of clinical minutes or dissemination via the practice manager. Staff said they felt they were well informed.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

Safe systems and processes including safeguarding

There were arrangements in place to safeguard adults and children from abuse. Staff were able to demonstrate they understood their responsibilities in recognising and reporting abuse and adhered to the practices safeguarding policies and procedures. Staff could give examples of where they had raised safeguarding concerns. Staff had easy access to procedures and contact details for organisations such as social services and had received safeguarding training. There were designated safeguarding leads for children and adults.

The practice participated in joint working arrangements and information sharing with other relevant organisations including health visitors and the local authority. This included the identification, review and follow up of children, young people and families living in disadvantaged circumstances, including children deemed to be at risk. There was a chaperone policy in place and staff who could be asked to chaperone had received appropriate training.

Infection Control

Appropriate standards of cleanliness and hygiene were followed. There was a designated clinical lead for infection control. There was an infection control policy in place and staff training was up to date. The practice had recently undertaken an infection control audit. The practice undertook some weekly spot checks but these were not written down so we could not verify this. We did find some out of date sterile wrapped instruments in doctors rooms. It was therefore no longer possible to know whether these instruments and equipment were sterile at the point of use, and could pose an infection risk.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out daily, which ensured medication was stored at the appropriate temperature.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing.

Equipment and Emergency Procedures

Medical equipment including emergency equipment, electrical equipment and fire detection and alarm equipment were all serviced and maintained according to appropriate schedules. The practice had procedures in place for medical and other emergencies and the business continuity plan contained emergency contact details which may be needed, such as emergency electricians or plumbers.

Good

Are services safe?

All staff received annual basic life support training and there were emergency medicines available in an accessible location. The practice had a defibrillator available on the premises and oxygen. All the emergency medicines we checked were in date and fit for use.

Staffing & Recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Rotas were planned in conjunction with staff according to predicted need, for instance after a bank holiday or to provide holiday cover. Staff told us there were enough staff to keep patients safe. Feedback from patients we spoke with and surveys confirmed they could get an appointment to see a GP or nurse when they needed to.

Monitoring Safety & Responding to Risk

Staff identified and responded to changing risks to patients who used the practice by monitoring them for deteriorating health and wellbeing. Patients with a change in their condition were reviewed and referred appropriately.

There were general procedures in place for monitoring and managing risks to patient and staff safety and there was a health and safety policy available. The practice manager carried out some regular building checks however these did not cover all areas of the building to ensure all risks were identified. A fire risk assessment had been carried out in 2014 but it was not logged which corrective actions had been carried out and which still needed to be done. The practice had not carried out regular fire drills and these needed to be instigated.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Assessing patient need and monitoring outcomes

The practice accessed current evidence-based guidance, standards, and best practice such as information from the National Institute for Health and Care Excellence (NICE) and other professional bodies. NICE guidelines were disseminated and discussed regularly at clinical meetings. The practice used this information to develop how care and treatment was delivered to meet needs. This included during assessment, diagnosis, referral to other services and the management of long-term conditions.

The practice collected information about people's care and outcomes. These included scores from national incentive schemes (the Quality and Outcome Framework, or QOF) and clinical audits. QOF results from 2013-14 showed the practice achieved 93.2% of the total points available, slightly below the national average of 94.2%. Most QOF results showed the practice preformed around national averages. For instance, the percentage of eligible women who had a cervical screening test performed in the last 5 years was similar to the national average of 81.88%, at 80.47%.

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was similar to the national average of 86.04%, at 85.42%. The local mental health care trust had produced a list of all their patients along with their care coordinators which the practice had incorporated into their computer records.

GPs carried out clinical audits. Examples of audits included a review of prescribing of high-risk medicines, and respiratory antibiotic prescribing. Subjects covered were in response to CCG requests, following an incident, or from GP reflection of practice. We saw in one audit that improvements had been made, including a systematic alert process in the patient record, and the identification of the lead member of staff to implement new arrangements.

The practice had produced a written annual health plan leaflet for patients with long term conditions, where patients could receive multiple reviews at a time for each of their condition, and take summarised information away with them.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. They also provided annual reviews to check the health of patients with learning disabilities and mental illness. The practice could produce a list of those who were in need of palliative care and support and held end of life planning discussions. Admissions to A&E were discussed monthly at the practice clinical forum. Patients requiring palliative care or with new cancer diagnosis were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The learning needs of staff were identified and staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, appraisals, and clinical supervision. Details of mandatory and non-mandatory training were recorded. All GPs were up to date with their appraisals and all other staff had received an appraisal within the last 12 months.

Staff received training that included: safeguarding, fire procedures and basic life support. Staff were able to access protected learning time (PLT) each month through the CCG where a variety of topics were discussed. The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality and the opportunity to shadow other members of staff. Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support.

Working with others and Information Sharing

Regular multi-disciplinary meetings were held with district nurses, health visitor, Macmillan nurses and clinical staff to identify and discuss the needs of those requiring palliative care, or safeguarding issues.

Blood results, discharge letters and information from out of hours providers was received electronically and reviewed daily by the attending doctor. Where necessary a procedure for scanning documents was in place. A flagging system was used to identify urgent test results and these were prioritised for action. The GP recorded their actions around

Good

Are services effective?

(for example, treatment is effective)

results or arranged to see the patient as clinically necessary. Patients were referred to hospital using an electronic referral system and used the two week rule for urgent referrals such as cancer. The practice used the Choose and Book system for referrals where possible. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice liaised with the out of hours provider regarding any special needs for a patient; for example regarding end of life care arrangements for patients who may require assistance over a weekend. 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.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health Promotion & Prevention

The practice offered all new patients an assessment of past medical history, care needs and assessment of risk. Advice was given on smoking, alcohol consumption and weight management. Patients with long term conditions or who were vulnerable were given an annual health plan and lifestyle advice which they could refer back to.

Nurses used chronic disease management clinics where patients were seen for multiple conditions to promote healthy living and ill-health prevention. Patients over the age of 75 had been allocated a named GP and were encouraged to attend for yearly health checks. Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. The percentages of patients aged 65 or over, or in a risk group receiving a flu vaccination were around national averages.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and conversations that took place in these rooms could not be overheard. The practice phones were located away from the reception desk which helped keep patient information private.

There was a chaperone policy and guidelines for staff. Nursing staff acted as chaperones where requested.

Patients we spoke with and the CQC comment cards we received indicated they were very satisfied with the service provided. Patients said they were treated with dignity and respect and that staff were pleasant and friendly. Patients said they were confident with the care provided and that staff took the time to listen to them. These high levels of satisfaction were also mirrored in comments made on the Friends and Family test.

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The practice scored around or slightly below average in the latest NHS England GP Patient Survey of 98 responses, for instance:

- 86% say the last GP they saw or spoke to was good at giving them enough time

Local (CCG) average: 90% National average: 87%

- 84% say the last GP they saw or spoke to was good at listening to them

Local (CCG) average: 91% National average: 89%

- 91% had confidence and trust in the last GP they saw or spoke to

Local (CCG) average: 96% National average: 95%

Care planning and involvement in decisions about care and treatment

In the latest NHS England GP Patient Survey of 98 responses,

- 94% say the last nurse they saw or spoke to was good at explaining tests and treatments

Local (CCG) average: 93% National average: 90%

- 79% say the last GP they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average: 86% National average: 81%

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff discussed care planning and supported patients to make choices about their treatment, including referral to specialist or community nursing staff. Extra time was given during appointments where possible to allow for this and multiple conditions could be discussed in one lengthened appointment.

Patients we spoke to on the day of our inspection, and comment cards received, 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. They said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us there was a translation service available for those whose first language was not English.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting different people's needs

The practice worked with the local CCG to improve outcomes for patients in the area and had recognised the needs of different groups in planning its services. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions such as COPD. Longer appointments could be made available for those with complex needs.

Home visits and telephone appointments were available where necessary. The building incorporated some features for people with disabilities, such as level access and accessible toilet facilities. There was no automatic door which may have caused difficulties to some patients. Treatment and consulting rooms were on the ground floor. There were longer appointments available for people with a learning disability. Urgent access appointments were available for children and those with serious medical conditions.

Access to the service

Information was available to patients about appointments on the practice website This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Appointments could be made in person, by telephone or online. Repeat prescriptions could also be ordered online. A mix of pre-bookable and 'on the day' appointments were available. There was no practice information leaflet available in the waiting area at the time of inspection, and staff had difficulty locating one when requested.

Telephone lines were open from 8:30am until 6:00pm Monday to Friday.

The latest NHS England GP Patient Survey of 98 responses showed patients were less satisfied with access to the service, for instance:

- 79% were able to get an appointment to see or speak to someone the last time they tried

Local (CCG) average: 88% National average: 85%

- 85% say the last appointment they got was convenient Local (CCG) average: 94% National average: 92%
- 72% describe their experience of making an appointment as good Local (CCG) average: 80% National average: 73%

Feedback from patients on the day was largely positive, however of the small number of negative comments received these were mostly concerning access to the service, in particular booking appointments with a named GP.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was displayed in reception.

We looked at a summary of complaints made during 2014/15 and could see that these had been responded to with an explanation and apology. Patients we spoke with said they would feel comfortable raising a complaint if the need arose.

There was currently no Patient Participation Group, although the practice was looking to actively restart a group and had also trialled a virtual patient group for emailed responses, although this had been unsuccessful in attracting 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, Strategy and Culture

The practice had objectives and a business plan, which were being reviewed in conjunction with staff one to one meetings, defining job roles and succession planning. Management staff were working on refining a mission statement, which was contained within a patient centred services policy. Staff were less aware of specific objectives, but described the values as friendly, personal patient centred care.

Staff we spoke with agreed that communication across the practice was good and they formed a strong supportive environment, where people worked flexibly and supported one another.

Governance Arrangements and Improvement

Staff were clear on their roles and responsibilities and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. All the policies and procedures we looked at, such as chaperone policy, infection control procedures and human resources policies had been reviewed and were up to date, or were in the process of being reviewed. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff within the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The practice regularly reviewed its results and how to improve. The practice looked to continuously improve the services being offered and wished to encourage and foster a learning culture. We saw evidence that they used data from various sources including patient surveys, incidents, complaints and audits to identify areas where improvements could be made.

The practice was able to demonstrate through the completed clinical audit cycles, improvement in the appropriateness and effectiveness of treatments offered to patients. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place.

The practice had arrangements for identifying, recording and managing risks. Management staff demonstrated awareness of potential risks and health and safety assessments which addressed a range of health, safety and welfare issues, such as legionnaires risk assessment or recruitment checks for staff.

Practice seeks and acts on feedback from users, public and staff

There was no Patient Participation Group (PPG), although the practice was looking to restart this group and recruit patients to it. Patients could leave feedback via the friends and family test or practice surveys. A brief action plan had been produced following the latest survey including restarting the PPG and considering late night opening.

All staff said they were confident in raising concerns or feedback.