Loughton Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Loughton Health Centre on 07 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all of the population groups we looked at.

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 action taken where required.
- Risks to patients were assessed and well managed.
- 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 were planned for.
- 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.
- Some patients and reception staff commented that it was occasionally difficult to obtain appointments. Urgent appointments were available the same day and emergencies prioritised.
- 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 sought feedback from patients through a well-supported patient participation group that was consulted about improving services.

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

Importantly the provider should;

- Establish a system to obtain patient feedback about the services provided from a broader selection of patients, such as a patient survey or other means.

Summary of findings

- Hold more regular team meetings with non-clinical staff to ensure they have the opportunity of providing feedback and are aware of other issues that may affect their role.
- Ensure that clinical and non-clinical audit cycles are completed in order to demonstrate improvements have been maintained.
- Ensure the complaints system is readily available for patients to access.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Significant events and complaints were analysed and learning identified which was cascaded to staff relevant to their role. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff had received safeguarding and basic life support training. Risks to patients were assessed and well managed. There were enough suitably qualified staff on duty at all times to keep patients safe. Emergency medicines and vaccinations were stored correctly and monitored for expiry dates. Patients had their medicines reviewed on a regular basis.

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 National Institute for Health and Care Excellence and used it routinely. Trainee GPs at the practice were up to date on current clinical procedures. Staff were aware of consent guidance including the action to take if a child under 16 years old attended the practice without a parent/guardian. Staff had received training appropriate to their roles and it met the needs of patients. Staff had received appraisals and were encouraged to develop themselves through further training. Staff worked with multidisciplinary teams to ensure patients received effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients were satisfied with the way they were treated by the GPs, nurses and other staff. Patients spoken with said they were treated with compassion, dignity and respect and involved in decisions about their care and treatment. Information informing patients about the services provided was available easy to understand. We observed that staff treated patients with kindness and respect and maintained confidentiality. Carers were identified and support offered to them. Carers were offered health checks and advice.

Are services responsive to people's needs?

Good

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

Summary of findings

secure improvements to services where these were identified. Patients spoken with expressed some difficulties booking an appointment at a time that suited them. There was an absence of patient views because the practice had not sought wide enough feedback from patients. Urgent health issues were prioritised and appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. The complaints procedure was not displayed for patients in the reception area. Complaints viewed reflected that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and visible leadership was in place. Staff were aware of the practice vision and their responsibilities in relation to it. Job descriptions and appraisals were meaningful and linked to the practice strategy. There was a clear leadership structure and most staff felt supported by management. Non-clinical staff felt that staff meetings should take place to give them an opportunity to contribute ideas for improvement and be more involved in the practice. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Staff had been allocated lead roles in relation to clinical and governance issues. There were systems in place to monitor and improve quality and identify risk. The practice had an active patient participation group (PPG) supported by the lead GP and practice manager. Staff had received inductions, and regular performance reviews.

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. All patients over 75 had a named GP. Wherever possible patients were able to see their own GP. Carers were identified and invited to attend the practice as a group to discuss their needs and identify where support was required. Home visits were available to those patients who were house bound. An independent pharmacy was located within the practice for the ease of patients. Home delivery of medicines was available. Staff were trained in safeguarding procedures in relation to the elderly and vulnerable and knew the different signs of abuse. The practice was pro-active in providing flu vaccinations for the elderly.

People with long term conditions

Good

The practice is rated as good for patients with long-term conditions. Patients had a named GP so they could receive continuity of care. Longer appointments were provided for those patients that needed them. Home visits and telephone consultations were available if they were unable to attend the surgery. Annual health reviews of patients with long-term conditions took place or sooner if required. Staff had received specialist training in respiratory care and diabetes management. Smoking cessation clinics were available. Patients identified as at risk of deteriorating health were monitored to reduce the risk of hospital admission. Multidisciplinary team working took place with other healthcare professionals to provide the right care and treatment and a package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Antenatal and post natal support was available for mothers and babies. Childhood immunisation rates were relatively high for all standard childhood immunisations. The nurses and GPs carried out six/eight week baby checks. Family planning advice was available including the fitting of contraceptive devices. Liaison took place with the community midwife. Staff were trained in safeguarding procedures in relation to children and young persons. Flexible appointment times were available so that children could be seen outside of school hours. Staff were aware of Gillick competence in relation to children under 16 requesting appointments without a parent/guardian being present.

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). Extended opening hours were available on Saturday mornings. Saturday morning flu vaccination clinics were available in the winter months. Health screening was available for patients to identify any healthcare issues and opportunities for prevention. Lifestyle advice was available for patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Patients with learning disabilities were included on a register and regularly monitored. They received at least annual health checks or earlier if required. Longer appointments were available so that issues could be discussed and understood. The facilities at the practice supported patients with disabilities. Carers were identified and offered appropriate support. The practice regularly worked with multi-disciplinary teams to manage patients care and treatment needs. Patients were signposted various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice worked with other healthcare professionals including mental health crisis and counselling teams. Longer appointments were available when necessary. Patients with dementia received an annual review of their health and daily needs. Partnership working was taking place to support patients and their carers. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection, comment cards were left with the practice for patients to complete about their views of the practice. Unfortunately none of the cards had been completed.

We spoke with seven patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. Patients did not feel rushed during consultations and they said staff were kind and caring. They told us that explanations were clear and care and treatment was delivered to a satisfactory standard. Some patients told us that it was sometimes difficult to get appointments. Other patients discussed that some consultations with a GP trainee were more likely to require a follow-up consultation with a GP partner to resolve health issues.

The patient had an active patient participation group (PPG) that worked with the practice to discuss areas for improvement. Three members of the PPG attended the practice on the day of our inspection and spoke with us. They told us that the PPG was well supported by the practice and the lead GP and practice manager attended each meeting, with meetings held regularly. They told us that the practice encouraged them to provide ideas and improvements. There were regular newsletters and these were displayed on a notice board in reception and placed on the practice website.

Areas for improvement

Action the service SHOULD take to improve

- Establish a system to obtain patient feedback about the services provided from a broader selection of patients, such as a patient survey or other means.
- Hold more regular team meetings with non-clinical staff to ensure they have the opportunity of providing feedback and are aware of other issues that may affect their role.
- Ensure that clinical and non-clinical audit cycles are completed in order to demonstrate improvements have been maintained.
- Ensure the complaints system is readily available for patients to access.

Loughton Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector accompanied by a GP specialist advisor.

Background to Loughton Health Centre

The Loughton Health Centre is situated in Loughton, Essex, just off the main high street. The practice is accessible by public transport (bus and train). The practice is one of 38 GP practices in the West Essex Clinical Commissioning Group (CCG) area. The practice has a primary medical services (PMS) contract with the NHS. There are approximately 12,200 patients registered at the practice. The practice undertakes minor surgical procedures.

The practice has six GPs working at the practice and they are all partners. One GP is designated as the senior partner. All partner GPs have lead responsibilities and management roles. There are both male and female GP partners. Loughton Health Centre is an established GP training practice. GPs who are training are attached to the practice for up to 12 months and work under the supervision of a GP partner.

The GPs are supported by four nurses and two health care assistants. There is a practice manager and an assistant practice, a business manager and a number of support staff who undertake various duties. There is a reception manager and a team of receptionists. All staff at the practice work a range of different hours including full and part-time.

The surgery is open Monday to Friday between 8am and 6.30pm. There is no early morning or late evening surgery. Surgeries run in the mornings and afternoons each day. There is also a surgery on Saturday mornings between 8.30am and 11.30am. The practice also opens occasionally on Saturday mornings in the winter period for flu vaccinations. The practice has opted out of providing 'out of hours' services which is now provided by another healthcare provider. Patients can also contact the emergency 111 service to obtain medical advice if necessary.

Why we carried out this inspection

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

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

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:

Detailed findings

- 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)

These questions therefore formed the framework for the areas we looked at during the inspection.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We then carried out an announced visit on 07 April 2015. During our visit we spoke with a range of staff including four of the partner GPs, four trainee GPs, two nurses, one healthcare assistant, the business manager and reception and administration staff. We spoke with seven patients who used the service and three members of the patient participation group. We observed how people were spoken with at reception and reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice but none of them had been completed.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. National patient safety and medicines alerts were received by the practice and sent to the GPs after a search of their computerised record system had identified those patients affected by the alert. Each GP received their own hard copy of the alert and were required to sign and return it to reflect that action had been taken.

We found that the system of disseminating the information was effective but there was no checking system in place to ensure that each GP had returned and had taken the necessary action. During our inspection the practice told us they would review this system to either carry out an audit of alerts to ensure they have been actioned, or other system to ensure the return of the completed documentation that reflects that the alert had been actioned.

Of those alerts we viewed we were satisfied that reviews had taken place and changes to medicines discussed with the patient and actioned. GPs spoken with displayed knowledge of the alerts and were aware of the system they were supposed to follow.

We spoke with several of the GPs, trainee GPs, nurses, reception and admin members of staff on the day of our visit who were aware of their responsibilities to raise concerns, and knew how to report incidents affecting safety. We also found that the partner GPs assumed responsibility for safety issues and discussed them at monthly partners meetings and sooner if required.

We reviewed significant events and complaints for the last 12 months and found that they had been investigated, analysed and learning identified. Action had been taken to reduce the risk of reoccurrence. Staff spoken with were aware of safety incidents that had occurred as there was a system in place for notifying staff of those that were relevant to their role at the practice. Minutes of the partner and clinical meetings reflected that safety was discussed at each meeting.

We did find that non-clinical meetings took place on an annual basis only due to the difficulties involved in arranging a time that suited everyone. The practice had made use of their IT system to ensure that all staff had an opportunity to learn from incidents and minutes were available for staff to read if they wished.

The practice was able to assure us that safety issues had been managed consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. This included encouraging all staff to report near-misses. We looked at six significant events that had occurred since May 2013. We found that they had been recorded, analysed, investigated and actions implemented where necessary.

The significant events we viewed reflected that where learning had been identified, feedback was given to staff members if relevant and patients offered a suitable explanation and apology. Some significant events identified where processes required changing to prevent reoccurrence. One such event related to a follow-up of a test result that had been allocated to a trainee GP that was absent from work and it had been overlooked. A review of this event took place and the system changed to prevent this from happening again.

Significant events and complaints were discussed at monthly partner meetings and if relevant at clinical meetings held every two weeks. These were minuted. The partner GPs assumed responsibility for the analysis and investigation of them. If necessary additional short notice meetings were arranged if there was a need to cascade information to clinical staff without waiting for the next scheduled meeting.

We found that although there was a system in place to notify non-clinical staff of the learning from safety incidents, due to the absence of a formal meeting there was no opportunity to discuss the issues and seek other ideas for improvements. Non-clinical staff spoken with displayed an awareness of the learning but did comment that they felt they were not involved enough and may have some ideas they could contribute in relation to a significant event or complaint.

Reliable safety systems and processes including safeguarding

Good

Are services safe?

The practice had a dedicated lead for safeguarding and this was one of the GPs. They had been trained to the appropriate level to manage safeguarding matters. The practice had identified safeguarding training to be mandatory for staff and all of them had been suitably trained.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a system to highlight vulnerable patients on the practice electronic record system through the use of coding. This included information to make staff aware of any relevant issues when patients attended appointments so they could be easily identified and offered additional support. The lead safeguarding GP was aware of those patients identified as vulnerable and was monitoring and reviewing them. Clinical staff we spoke with were aware of the alert system on the patient records. This included children at risk and vulnerable adults.

We spoke with several members of staff on the day of our inspection and found that they had received safeguarding training and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. They were also aware of the safeguarding lead at the practice.

A whistleblowing lead had been identified and this was one of the GPs. Staff had received training in whistleblowing and knew who to consult at the practice or externally that could provide support if necessary.

There was a chaperone policy and staff undertaking these duties were aware of its contents. (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). Only qualified staff who had received training acted as chaperones. This was usually clinical staff such as nurses or a healthcare assistant. They told us that they were always in view of the patient and could see any examination clearly. This protected both the GP and the patient. Patient records were updated to reflect that a chaperone had been in attendance at the consultation. A chaperone sign was clearly displayed in the reception area for the information of patients and there was further information in the practice leaflet.

Medicines management

We looked at how medicines were stored in the medicine fridges 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. Records had been kept that reflected that the fridges in use were operating in the correct temperature ranges. The practice staff followed the cold chain policy when medicines arrived so that they were placed in a fridge as soon as possible.

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. This included the medicines available in the event of an emergency at the practice, the GPs emergency bag used when conducting home visits with patients and stocks of vaccinations used by the nurses at the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance.

The practice was aware of their prescribing patterns from the data that was available to them. They had noticed an increase in their anti-biotic prescribing and were monitoring it. A meeting had been planned to discuss prescribing patterns with all GPs to ensure that they were prescribing medicines appropriately.

All prescriptions were reviewed and signed by a GP before they were given to the patient. This included checking whether a medicines review was due. A system was in place on the computerised patient record system to identify patients who were due for a review and this was being actioned.

The practice had an independent pharmacy located within the building, available during practice opening hours so that patients could leave and collect their dispensed prescriptions. Information about this was available to patients at reception, in the practice leaflet and on their website.

Cleanliness and infection control

The practice had a lead for infection control who had received appropriate training. An infection control policy was available to support staff. This included infection control procedures, the management of needle-stick injuries and clinical waste management.

Good

Are services safe?

Infection control training had been designated by the practice as mandatory for all staff and this was effectively monitored. We viewed a sample of staff files and found that they contained details of infection control training. An infection control inspection had taken place by an external company in May 2013 in order to identify whether the practice was following best practice guidance. This identified a number of areas where improvements were required and these had been actioned. An infection control audit had been undertaken in the last 12 months and where areas for improvement had been identified, these had been actioned.

We saw that cleaning schedules were in place that identified the type of cleaning required and the frequency. Checklists had been completed by staff on a daily basis that reflected cleaning was being undertaken. We looked at the records for January to March 2015 and found that they had been completed as required.

The room allocated for minor surgical procedures had a robust cleaning procedure in place due to the increased risk of infection from invasive procedures. The checklist covered cleaning surfaces between patients and a monthly deep clean. We spoke with a nurse and a healthcare assistant responsible for this room who discussed with us the efforts they made to maintain this room as hygienically as possible. Records had been kept to display that the cleaning schedules had been complied with and they had been dated and initialled as completed. We found that the room was clean, hygienic and uncluttered.

We observed the premises to be visibly clean and tidy. This included the consultation and treatment rooms, the reception and waiting area and the toilet facilities. There were adequate supplies of paper towels and liquid soaps for the use of patients and staff. Hand sanitising gel was available in the practice for patients to use.

Clinical staff had received inoculations against the risk of Hepatitis B and it was also offered to non-clinical staff. The effectiveness of this was monitored through blood tests. Clinical waste was handled correctly and a waste management contractor had been appointed to collect it on a regular basis. It was being stored safely prior to collection. Sharps bins were sited correctly, signed and dated.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a policy for the management, testing and investigation of legionella (Legionella is a term for particular bacteria which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient quantities of equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly.

All portable electrical equipment was routinely tested and records we viewed reflected that this had been taking place. The latest testing took place in October 2014. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and blood/sugar testing equipment for patients with diabetes. Calibration testing had been booked for this year and was due to take place in the near future.

Staff told us that when equipment was running low an effective system was in place for re-order so they did not run out of important equipment. They said the practice was pro-active in ensuring they had the right equipment to do their job.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included the documentation required including proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

The practice had made a decision that all clinical staff would be required to undertake a DBS check but this was not required for non-clinical staff such as those working in an administrative function or as receptionists. The practice assured us of their rationale in relation to this and that any

member of staff who might be asked to act as a chaperone, or if asked to look after children alone for some reason, then a DBS check would be obtained, prior to them undertaking that role.

We looked at three staff records and found that the correct documentation was contained within them. We found proof of identity, DBS checks, references and qualifications within the files and for clinical staff, appropriate checks had been made with their professional bodies.

The practice ensured that staff were appropriately trained to meet the needs of the patient population. Staff training was monitored and reviewed to ensure the right mix of skills and experience supported the patients.

Seasonal variations in demand had been assessed and additional staff made available during the winter flu season when the practice opened on some Saturday mornings. Where GP levels reduced at peak holiday times, locum GPs were contacted to provide additional support.

There were a number of staff members who shared job roles on a part-time basis. This did not impact on the effectiveness of the practice as they worked as part of a team and supported each other. 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. They said that they often covered for each other at times of annual leave, sickness or when training had been organised.

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. A health and safety risk assessment had taken place that identified the risks to both patients and staff. Regular checks of the building and the environment took place and staff were encouraged to report any maintenance issues that presented a risk.

There was a system in place to respond to risks identified at the practice in relation to faulty equipment or fixtures and fittings. Where issues had been discovered, timely repairs had taken place

Other systems were in place to monitor risk including medicine reviews for patients, handling national patient safety and medicines alerts, dealing with emergencies and the servicing, maintenance and calibration of medical equipment.

Patients suffering from conditions making them more vulnerable were identified and monitored through the use of registers and a multidisciplinary approach with other healthcare professionals. This provided a systematic, organised approach to identify patients at risk of their health deteriorating rapidly so that care plans could be put in place to support them. The practice provided an emergency supply of medicines for some patients with long-term conditions such as chronic obstructive pulmonary disorder, in the event that they needed them urgently because their health had deteriorated rapidly.

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 and the practice had decided this was mandatory. Emergency equipment was available including 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 attempt to restore a normal heart rhythm). The chest pads used with the defibrillator were in date and available for children and adults.

We found that the basic life support training included a simulated incident where staff had to respond to an emergency. This highlighted to them an area for improvement in relation to the location of emergency medical equipment. As a result of this simulation training their system was changed to enable them to handle an incident more efficiently.

Emergency medicines and equipment were available in a secure area of the practice and all staff we spoke with knew of their location. We checked the equipment available and found that it was of the recommended type and variety. 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 of the recommended type. Records had been kept to reflect this was checked on a regular basis.

Staff working at the practice were required to undertake fire emergency procedures. We were told that two fire drills had been practised in the last 12 months and staff members confirmed this with us. The local fire brigade had attended to provide advice on their systems and processes and they

Good

Are services safe?

had followed their guidance. Fire alarm servicing had been undertaken and the equipment was found to be in working order. A fire drill protocol was in place and fire extinguishers were in date and suitably placed allowing easy access for staff.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This document contained relevant contact details for staff to refer to and external organisations that would be able to provide the necessary support required to maintain some level of service for their patients. These included the action to take in the event of a power failure, adverse weather and unplanned sickness.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with four GPs, four trainee GPs, two nurses, and one healthcare assistant on the day of our inspection. We found that consultations were being carried out in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff had ready access to the guidelines through their local intranet and could refer to them when necessary.

We found that the GPs consulted regularly on current NICE guidance to ensure that they were providing the most up to date consultations possible to achieve positive outcomes for their patients. Where junior GPs were undertaking their own consultations, a senior GP was always available to seek advice when necessary.

There was an effective system in place to monitor national patient safety and medicines alerts. These were sent to the practice and reviewed by each GP for their own patients. Any relevant information was then disseminated to other clinical staff such as nurses so they were aware of issues relevant to their role. The GP reviewed the information form the alerts. This often included undertaking audits of patients on the medicines identified as being potentially unsafe, and then conducting a review as to whether they should continue to be prescribed or an alternative offered. This helped ensure patients received effective consultations and treatment.

The GPs and nurses specialised in a number of clinical areas such as diabetes, heart disease and asthma. This supported the needs of patients who were able to receive appropriate monitoring, along with advice and guidance as to how best to manage their condition and maintain a healthy lifestyle.

Patients with long term conditions and those approaching the end of their lives through illness had their needs assessed and were provided with effective care and treatment. Registers were in place and other healthcare professionals were involved in assessing their needs and planning their care. Patients and their carers/families were signposted to support from external organisations, such as Macmillan nurses and health visitors.

Where any assessment revealed a more complex diagnosis, patients were referred to specialists and other services in a timely manner and where urgent, often on the same day. We were told by staff responsible for the referrals that the system was effective and patients were referred in line with national timescales and that there was no backlog of referrals waiting to be made.

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

The practice monitored their performance using the Quality and Outcomes Framework (QOF). The 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 such as diabetes and implementing preventative measures. The results are published annually.

The practice held monthly meetings to discuss their QOF performance and staff in key roles were made aware of the current position in relation to performance measurement. This ensured that staff were aware of whether their targets were being met so that they could take action if necessary to improve performance. We found that there was a pro-active approach by the practice in the management of patients with long-term conditions to monitor and improve their conditions.

Staff across the practice were involved in monitoring outcomes for patients. These roles included data input, accurate coding of patients' conditions, scheduling clinical reviews, and updating patient records when they were discharged from hospital. The information staff collected was then collated to support the practice to achieve their QOF targets. Practice staff then checked this information when a patient attended for a consultation and they were alerted if a review was due, then it was actioned.

We looked at the QOF data available to us for the year April 2013 to March 2014 and found that the practice had performed in line with the national average for other GP

Good

Are services effective?

(for example, treatment is effective)

practices. The practice showed us data in relation to their performance to the year end March 2015 and this reflected that patients with long-term conditions were being monitored effectively.

The practice had a register of patients with palliative care needs and monthly multidisciplinary meetings took place where the care and treatment of individual patients was monitored and discussed. This identified the most appropriate care and treatment for them and allowed them to be treated in their own homes if they so wished. Other healthcare professionals involved in this process included district nurses, social services and Macmillan nurses.

We looked at the palliative care register for the most recent review of patients for April 2015 and were satisfied that a multidisciplinary approach was being adopted. The register identified the patient's condition, their preferred place of care, the support they required and their anticipated needs.

The practice also maintained registers for patients with dementia, those suffering from poor mental health and those with learning disabilities. They were monitored and received an annual health review and were offered advice and guidance to support them to manage their condition.

The practice monitored and reviewed patients with many other health conditions including hypertension, asthma and chronic obstructive pulmonary disorder (the name for a collection of lung diseases, including chronic bronchitis and emphysema). Data available from QOF reflected that the practice was monitoring patients with these illnesses effectively.

In relation to patients with diabetes the practice was aware that their monitoring and review processes were below the national average. This included health reviews, blood/sugar levels and foot examinations. A clinic for those with diabetes ran twice each month with a nurse qualified in diabetes management and one of the GPs in attendance. This included securing the attendance of a chiropodist and a dietician whenever possible. The practice was taking steps to improve their monitoring of patients with diabetes. In particular they had agreed training for their health care assistants to enable them to undertake foot assessments and they were changing their clinic procedure so that it was more effective.

The practice monitored their patients who had attended the A&E department for care and treatment. This was undertaken monthly and included patients suffering with poor mental health, dementia, older patients, those with long-term conditions or otherwise vulnerable. The practice worked with other healthcare professionals to anticipate their healthcare needs to prevent further attendance or hospital admissions.

There was a protocol for repeat prescribing which was in line with national guidance. This ensured that the use of medicines was reviewed to ensure they were effective and safe for continued use. Support staff preparing routine prescriptions regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. A system was in place on the practice electronic record system that highlighted when a review as due.

Appropriate audits had also been carried out in relation to alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). This involved identifying patients on medicines where a risk had been identified, then reviewing the need for the medicine and then changing it if required, after discussing it with the patient.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had decided which training was mandatory; this included safeguarding, basic life support, information governance, infection control and fire training.

We reviewed the training records and saw that staff training was being monitored to ensured staff were up to date with attending relevant courses. The records reflected the date of the last training and when the next one was due.

At the time of our inspection the business manager was deputising for the practice manager and had done so for over six months. They told us that they felt supported by the partner GPs who they met with regularly each month where practice issues and performance were discussed.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

Good

Are services effective?

(for example, treatment is effective)

The practice was a teaching practice where trainee GPs worked on a rotation basis for a number of months. We spoke with four trainee GPs who told us felt they were supported by all of the GPs at the practice. A system was in place where they could consult a more senior GP during surgery hours if they were unsure of any issue. They said that their performance was the subject of regular review and that advice and guidance was always available. Part of the process was regular meetings with one of the GPs who had been allocated to them as a mentor.

The trainee GPs told us that the support mechanism in place was very useful to them as they had the opportunity to discuss consultations and undertake case studies to improve their skills and give them valuable experience. They told us that they would be happy to work at the practice once qualified.

All clinical and non-clinical staff received annual appraisals that identified learning needs from which action plans were documented. Staff were set objectives and their performance was monitored throughout the year and they were graded to reflect their achievements.

Staff spoken with had all received appraisals and felt they were fair and meaningful. They told us that development opportunities were discussed with them and that the practice was proactive in providing training and funding for relevant courses where it met the needs of patients.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. This included the administration of vaccines, cervical screening and managing and supporting patients with long term conditions such as diabetes. Staff were able to demonstrate that they had appropriate training to fulfil these roles.

The nurses and the healthcare assistants at the practice held smoking cessation clinics, assisted with minor surgical procedures, supported GPs administering joint injections and managed patients with dressings for any wounds they had.

Nursing staff we spoke with told us they were encouraged to undertake their continual professional development to maintain their skill levels. This is a schedule of learning and additional training on a five year cycle where nurses are required to complete a specific number of hours training to maintain their registration with their professional body.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

Each GP had their own patients. Any information received about a patient was sent to the nominated GP to assess the level of clinical input required before being transferred to the patient's record by a member of the administration staff. Where a follow-up was required patients were contacted by phone or letter and requested to attend the practice so a review could be undertaken. Each GP was responsible for dealing with their own nominated patient's letters and results to ensure continuity of care whenever possible.

We spoke with two members of the administration team who told us that records were updated the same day on almost all occasions and there was generally no backlog of outstanding information waiting to be included in the patient's records. They told us that each GP dealt with their allocated records in a timely fashion. They said that the GPs made it clear on records they had viewed, whether contacting a patient was routine or urgent and these were actioned appropriately.

The practice held multidisciplinary team meetings monthly for those patients with long-term conditions, end of life care needs or children on the at risk register. These meetings were attended by a variety of other healthcare professionals including district nurses, social workers, and palliative care nurses. The needs of patients were discussed individually and decisions about care planning were documented.

Patients requiring appointments with specialists were referred using the 'choose and book' system. (Choose and book is a national electronic referral system which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Patients spoken with on the day of the inspection told us that they received an appointment soon after their referral and were satisfied that the system was working effectively. We found that urgent referrals were being dealt with on the day whenever possible.

Good

Are services effective?

(for example, treatment is effective)

The practice worked with the A&E department of the local hospitals. When patients attended A&E and the initial assessment by hospital staff was this it was not an emergency, the practice were contacted and they offered a same day appointment to be seen by a GP back at the practice. This was a service to encourage the most appropriate use of A&E resources. If a patient did not attend for the appointment, they were made available to other patients.

The practice had carried out an audit to test the effectiveness of this system but unfortunately had not received any contact from the A&E department referring patients back to them.

Information sharing

The practice used an electronic patient record system for the patients at the practice. This coordinated, documented and managed patients' care. All staff were fully trained on the system and able to use it effectively to record and monitor their patients. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Information was shared with other healthcare providers such as the local GP out-of-hours service. When patients had the need to use the service the results of the consultations were provided to the practice by 8am the following day and patient records updated. This ensured that patient data was shared in a secure and timely manner and gave GPs the information they needed to enable them to follow-up the patient if required.

Electronic systems were also in place for making referrals for patients who required specialist healthcare advice. The locally used system required a referral to be made to a central location where the most appropriate pathway was decided upon. Then patients received their referral. This usually took less than two weeks from the initial consultation with the GP to receiving an appointment date with a specialist.

A member of staff had been appointed to summarise patient records onto the computerised patient record system. Staff were aware of the need to maintain confidentiality when sharing information with other healthcare professionals.

Consent to care and treatment

A consent policy was in place that identified the different types of consent that could be obtained including implied, verbal and written. Staff had signed this policy to indicate it had been read and understood.

We found that clinical 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.

Clinical and reception staff we spoke with were aware of Gillick consent in relation to children under the age of 16 who wished to consent to care and treatment without a parent or guardian being present. They told us that if a child under the age of 16 attended for an appointment with a GP or nurse without a parent or guardian and they indicated that they did not want one present, they would be given an appointment. The GPs we spoke with were aware that they then had to apply the Gillick competency test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The GPs we spoke with were clear about assessing the mental capacity of patients who might be suffering with dementia or those with a learning disability. This included whether a decision was required to be made in their best interests. We were satisfied that correct procedures were being followed.

Nursing staff were aware of the need to consider whether a person attending with a child had the legal right to agree to consent to treatment on their behalf. This included where child immunisations were due and when a child attended with a person that might not be legally entitled to consent to treatment on their behalf, such as a step-relative or grandparent.

Consent forms were available for staff to use and these were used routinely when undertaking minor surgical procedures, joint and vitamin injections and the fitting of contraceptive devices.

Health promotion and prevention

New patients registering at the practice were offered a health check with a GP. Health checks were also offered to

Good

Are services effective?

(for example, treatment is effective)

patients aged between 45 and 74 and for those over 75. There were systems in place to identify the patients eligible for these health checks and letters and text reminders were sent to patients to encourage them to attend the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was above average for the Clinical Commissioning Group area. The practice provided us with data for the year end to March 2015 and this reflected that they had achieved a 97% coverage of childhood immunisations and 91% for boosters.

Flu vaccinations were available for elderly patients or those with conditions that made them vulnerable to the virus. During the winter months the practice opened on several Saturdays to provide patients an opportunity to attend for their flu vaccination out of normal surgery hours. The practice was aware that their flu vaccination uptake was not in line with other practices. However they had systems in place to encourage patients to attend their flu clinics including the use of text messages, phone calls, letters and reminders on prescriptions. They were monitoring their performance and felt that they had reached those patients most vulnerable.

Patients could also attend the practice for smoking cessation advice and smokers were identified through the patient record system and pro-actively contacted to attend the practice. Of 70 patients attending smoking cessation clinics between April 2014 and March 2015, 23 had given up smoking.

Cervical screening was available for patients at the practice. If a patient did not attend for a test there was a system in place to attempt further contact with patients to remind them to attend. Where a test indicated that a follow-up appointment was required practice staff contacted patients and asked them to attend the practice to discuss the test result. Data available to us reflected that over 80% of women eligible for cervical screening had received it in the year end of 2014.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with told us that they treated patients with dignity and respect. They told us that where a confidential matter needed to be discussed patients would be taken to a private room.

Staff acting as chaperones told us that consultations were undertaken with dignity in mind and privacy screens used when the examination was more intimate. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Signs were available in reception advising of the availability of chaperones.

The practice was a training practice and GPs in training saw patients on their own or sometimes with a more senior GP. A sign was clearly displayed in reception describing this and patients were advised that they could be seen alone if they preferred it. This respected their dignity and confidentiality.

Information from the national patient survey undertaken in January 2015 reflected that patients were satisfied with the way they were treated at the practice. The survey reflected that 78% of patients found the receptionists helpful, 91% of patients found that the nurses at the practice treated them with care and concern and 86% said that the GPs gave them enough time.

We spoke with seven patients on the day of the inspection. They told us that GPs, nurses and reception staff were kind and caring and treated them with respect. Patients did not feel rushed and felt that they received safe care and treatment.

A system was in place for patients to call the practice to obtain test results. Staff told us that the identity of the caller would be confirmed before passing on personal information. Patients were able to consent in writing if they wished a relative or carer to receive test results on their behalf.

Care planning and involvement in decisions about care and treatment

The national GP patient survey from January 2015 reflected that 80% of patients said that the last GP they saw or spoke with involved them in decisions about their care and treatment. This figure was 85% for the nursing staff. Also, 81% felt the GP was good at explaining treatment and results and 93 % said the same about the nurses.

We spoke with seven patients on the day of the inspection and they told us that the GPs and the nurses involved them in the decisions about their care and treatment. They told us that health issues were discussed with them and they felt listened to and supported by them. They said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patients who were elderly and vulnerable, those with long-term conditions or with complex issues were identified and recorded on a register. Their on-going care and treatment was discussed with them and they were involved in the care and treatment decisions and plans.

Patient/carer support to cope emotionally with care and treatment

Information was available on the practice website to provide patients with an explanation of the procedures to follow in the event of bereavement. Staff told us that if families had suffered bereavement, they were made aware of it so they could provide appropriate support when they attended the practice. This included a GP consultation if required or to signpost them to organisations that could provide support.

Practice staff were pro-active in identifying those people with caring responsibilities and they were then offered advice, guidance and signposted to external organisations where further support could be obtained. The practice was involved in supporting a Carer's Café, where carers could meet up and discuss good practice, receive support and meet in a social environment.

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

Good

Are services caring?

On the day of the inspection we spoke with a carer of a person with learning disabilities. They told us they had received good levels of support from the practice, including referrals to specialists when they were required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

The practice had an established patient participation group (PPG) and the GP and practice manager met with them regularly. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). Suggestions for improvements in the way it delivered services were sought for them and ideas adopted if relevant and of benefit to patients. We spoke with three members of the PPG who told us that the practice were supportive of their role and included them in matters relating to the practice.

Data available to us from the NHS national patient survey from January 2015 reflected that 91% of patients said that the last GP they saw was good at listening to them and 95% for the nursing staff. This was higher than the average for similar practices in the area.

Systems were in place for older people to access the care they needed. Patients over 75 had a named GP and received continuity of care. The national patient survey results showed that 48% of patients could see a GP of their choice.

The practice was pro-active in obtaining the most up to date mobile telephone numbers of their patients. They then used them to send text message reminders about appointments and for their flu vaccination programme. They also contacted patients by phone and by letter to provide information on the services available to them.

Patients who were house bound were able to order repeat prescriptions by phone without the need to attend the surgery. Other patients completed request forms and left them in a box in reception, provided for that purpose or could order them online after registering with the practice. They were dealt with within 48 hours.

Patients experiencing poor mental health received an annual physical health check and longer appointments were available for this purpose. The practice worked with other healthcare professionals including mental health crisis and counselling teams. Referrals were made to external agencies that could provide additional support.

Patients with dementia were supported by the practice. They were given an annual health review of their health and their condition monitored. Information about external support agencies was available in the reception area for patients/carers to access. Appropriate referrals were made to local dementia care services so that patients could be provided with care and support.

Patients with learning disabilities were identified and included on a register so they could be regularly monitored. Annual health checks took place or earlier if required. Longer appointments were available so that issues could be discussed and understood.

Maternity services were available for mothers and babies. The GPs provided full antenatal and post natal care during normal surgery hours. Patients registered their babies with the practice and could book a consultation with one of the GPs when their child was six to eight weeks old. Information was available in the practice leaflet and on the website, including an immunisation schedule. Mothers and their babies could also be seen by community health visitors at a nearby clinic.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to their premises so that disabled patients and those with limited mobility could access the service easily. There was a ramp available for patients using wheelchairs and for parents with prams. A support rail was also in place leading into the premises. The main doors to the practice opened automatically.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and also those with prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice had access to online and telephone translation services for those patients who had limited English. Some staff at the practice also spoke other languages and were able to support patients. A hearing loop was available for those with hearing difficulties and braille signs had been posted around the surgery.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments could be booked by phone, online or by attending personally at the practice. Patients were encouraged to book in advance for a routine appointment. Surgeries were held between 8.30am and 11.30am and 3pm to 6.30pm on Monday to Friday and Saturdays between 8.30am and 11.30am. On occasional Saturdays in the winter the practice was also open to provide flu vaccinations.

Routine appointments were able to be booked in advance for non-urgent matters. This often meant that a patient could see the GP of their choice more frequently. A text message appointment reminder system was also in place. Telephone consultations and home visits were also available.

Each GP at the practice had a number of appointments for urgent matters that were only released on the day. In addition a duty doctor system was in place each evening for patients with urgent health care needs and appointments were for five minutes duration and strictly for emergencies. Times for this session varied but patients could establish the arrangements by calling the practice on the day.

On the day of the inspection we spoke with one patient who was able to get an urgent appointment for their children that day. They told us that there was good appointment access for children.

The standard appointment duration is generally of 10 minutes duration. This is typical across GP practices nationally. This practice had decided to offer appointments of 15 minutes duration to ensure that patients had sufficient time to discuss their health care needs and for GPs to conduct effective consultations. Patients could request a longer appointment if they had a number of issues to discuss. Patients with learning disabilities or those suffering from poor mental health were allocated a double appointment if necessary.

Appointments were available with the nurse for cervical smear testing, childhood vaccinations and travel immunisations during normal surgery hours. Nursing staff were not generally available at weekends unless a flu vaccination clinic was open during the winter.

The nurse saw patients with learning disabilities before their annual review to undertake blood pressure, height and weight checks before their appointment with the GP. In advance of an annual review, questionnaires were sent to patients with learning disabilities and their carers to help identify their care needs. These were then discussed at the review with the GP.

Reception staff we spoke with told us that the appointment system was the subject of comment by a number of patients. In particular they found that some patients felt there was a lack of choice, they could not see a GP of choice and that the mentoring of trainee GPs took place when patients wanted to see a GP and as a result of the mentoring process, GPs were sometimes unavailable. They told us that there were no issues for patients wishing to see the nurses at the practice.

To aid the GP surgeries to run on time, patients could book in for their appointment using an automated patient check-in system. This was user friendly and reduced queuing at reception which could cause delays to see the GP and allowed reception staff to concentrate on other duties such as telephone queries.

Information was available to patients about the appointment system 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 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.

Listening and learning from concerns and complaints

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

The reception area did not contain information about the complaints procedure for patients to read. Reception staff we spoke with told us that they did not have access to a complaints form or a leaflet that they could give to a patient that explained the procedure. The practice stated that any complaints could be made verbally or in writing to the practice manager.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We viewed seven complaints that had been received by the practice since the beginning of 2015. We found that they had been recorded, analysed, investigated and areas for improvement identified. Where appropriate, patients were given a suitable apology and/or invited into the practice to discuss the issue. The practice responded in a positive way to the complaints they received and investigated and analysed them effectively. Learning was discussed with staff at clinical team meetings and cascaded to non-clinical staff informally.

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 statement of purpose that described a clear vision to deliver high quality care and promote good outcomes for patients. The practice aim was to ensure high quality, safe and effective general practice services, committed to the health needs of all our patients.

- The practice vision and values included working in partnership with their patients, families and carers to ensure mutual respect and holistic care, encouraging them to participate fully to express their needs and enabling them to maintain the maximum possible level of independence, choice and control.

Throughout the inspection it was clear from speaking with staff that their job descriptions, roles and ethos were linked to the practice vision and values.

Governance arrangements

The six partners at the practice met monthly with the practice manager where governance arrangements were discussed. Minutes of these meetings were recorded and we viewed three sets of them. We found that key issues were discussed including significant events, complaints and performance. Actions as a result of these discussions had been clearly recorded and action taken in a timely manner.

The practice had identified lead roles for a number of staff at the practice. There were leads for infection control, safeguarding, diabetes, minor procedures, health and safety and information governance. There was a practice manager, a business manager and a reception manager. We spoke with the clinical and non-clinical staff and all were aware of the staff members in leadership roles. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice carried out a number of audits to monitor the quality of the services they provided. These included both clinical and non-clinical audits. Some audits we viewed included a prescribing audit for a particular medicine, the monitoring of patients with osteoporosis, A & E attendance and appointment availability. Areas for improvement had been identified and actioned but a follow-up audit had not yet taken place to reflect that any improvements had been maintained over the longer term for the benefit of patients.

The practice had a range of policies and procedures in place to govern activity and these were available to staff within the practice. We looked at four of these policies and procedures and found they were fit for purpose.

Leadership, openness and transparency

The practice had six partners who all met monthly with the practice manager. They discussed a variety of topics including the direction of the practice and leadership issues. Information from this meeting was then cascaded to clinical staff at a meeting for clinical staff only. This meeting took place every fortnight or more frequently if required. Both meetings were minuted.

Non-clinical staff received feedback from the leadership and clinical meetings through their IT system and informally. Where a situation arose that required a more formal meeting, such as important learning from a safety incident an ad hoc full staff meeting was arranged. Minutes were not taken of these meetings.

Non-clinical staff we spoke with told us that there were no regular team meetings held for non-clinical staff and they felt this was a missed opportunity to actually discuss learning or performance issues and to offer their own ideas for improvements. They felt that they were not included in the day to day matters of the surgery and for this reason did not always feel part of a team. However they did say that the partners and managers were open and transparent and they felt confident to raise any issues without fear of recrimination. They said there was a no blame culture at the practice.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG). This is a group of patients registered with a practice who work with them to improve services and the quality of care. On the day of the inspection we met with three members of the PPG.

We were told that there were regular quarterly meetings attended by the lead partner GP and practice manager. There were approximately 18 members and at least 10 of them attended the meetings on a regular basis. They told us the relationship with the practice was productive and

Are services well-led?

Good

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

ideas for improvement encouraged and supported. One such recent example was when the practice extended the hours a duty doctor was available until 6.30pm each day for routine and urgent booked appointments.

The PPG produced a regular newsletter which was placed on the practice website and displayed on a dedicated PPG notice board in reception. To date there had been 31 newsletters produced. Patients were encouraged to join the group and forms were available in the reception area. The practice website was also used to canvass new members and the PPG was promoted using information attached to prescription slips.

Clinical staff attended regular staff meetings and ideas for improvement were sought from them. Non-clinical staff told us that feedback was sought from them at annual appraisals only. They said that there was no system in place to obtain their feedback or to discuss the issues arising out of complaints and significant events. They said they had identified areas where the practice could improve, particularly in relation to the appointment system, after minor complaints had been received from patients, but they had not been asked for their views.

We therefore found that the absence of non-clinical regular staff meetings meant that not all staff were routinely asked for their views about the services provided and therefore opportunities for identifying areas for improvement may have been missed. This included a system for recording minor issues raised by patients to reception staff that otherwise would not be the subject of a formal complaint.

The practice had recently started the NHS Friends and Family test (FFT). This is a test where patients are requested to complete a short questionnaire about their experience at the practice. Forms were available for patients to complete in the reception area and also on the practice website. The results of the family and friends test for January, February and March 2015 indicated that the majority of patients were either extremely likely or likely to recommend the practice.

The practice had not undertaken a patient survey about the services provided. This meant that a broad range of patient views was not available to enable the practice to assess whether the patients were satisfied with the services provided. Although we accept that some feedback had been received about the services provided from patients who were members of the PPG and from the patients that had completed the FFT, this was not reflective of a patient population in excess of 12,200.

Results from the national patient survey reflected that in some areas of service provision there was potential for improvement. In particular, the national patient survey reflected that 45% of patients found it easy to get through to the practice by phone, 48% with a preferred GP usually got to see that GP and 75% were able to get an appointment to see or speak to someone the last time they tried. There was no evidence available that the practice had responded to this data. On balance there were some areas where the practice was highly rated. These included 93% of patients stating that their last appointment time was convenient, 91% said that the last GP they saw or spoke with was good at listening to them and 93% said that the last nurse they saw or spoke to was good at explaining tests and treatments.

These statistics supported the opinion that there was a need for a broader patient viewpoint in order to identify whether patients were satisfied with the services provided.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. On one day every three months the practice closed for a day and provided training for their staff. This also gave staff an opportunity to discuss issues and areas for improvement. Staff we spoke with confirmed this took place and that it was useful.

Staff we spoke with told us that they were given annual appraisals where they were able to discuss their learning, development and training needs. They said the process was meaningful. Although we were unable to view appraisals on the day of our visit due to IT issues we were assured that they had taken place.

The practice had completed reviews of significant events, complaints and other incidents and shared with clinical staff at team meetings. The practice made use of the IT system to notify non-clinical staff of the learning from such incidents and occasionally held ad hoc meetings where there was an urgent need to discuss a particular issue. Staff spoken with had an awareness of the incidents that had occurred in the past. However they told us they did not

Are services well-led?

Good

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

have a regular opportunity to be involved in a discussion about issues that had arisen or to be given the opportunity to offer ideas for improvements. A full staff meeting did take place annually.

The lead GP attended monthly collaborative learning events with other practices in the local area. Where good practice was identified this was cascaded to relevant staff at the practice.