St Johns Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 21 November 2014 as part of our new comprehensive inspection programme. The practice also has a branch surgery at Wychbold which we did not inspect on this occasion.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

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

The practice should:

- Ensure all GPs complete infection control training including regular updates as required.
- Ensure that all GPs can be assured that referral letters contain accurate information prior to correspondence being sent to consultants.

Summary of findings

- Ensure clinical meetings are formalised and minutes kept, particularly when guidelines are updated to ensure that the whole clinical team are aware of current best practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, 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. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

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 (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. The practice worked to the Gold Standard Framework (GSF) for palliative care. The GSF is a practice based system to improve the quality of palliative care in the community to enable patients to receive supportive and dignified end of life care where they choose.

Nationally reported data showed the practice had good outcomes for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice had committed to providing services to the wider community through the virtual ward scheme. A virtual ward is a term used for providing support in the community to people with the most complex medical and social needs.

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and

Summary of findings

babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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 age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities.

The practice regularly worked as part of multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff told us they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with a learning disability. The practice had carried out annual health checks for people with a learning disability. Longer appointments were made available for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were informed about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in

Summary of findings

vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

What people who use the service say

We spoke with six patients on the day of the inspection. Patients told us they were extremely satisfied with the service they received at the practice. They told us they could always get an appointment at a time that suited them, including same day appointments. They had confidence in the staff and said that staff were always helpful and respectful.

We reviewed the seven patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that six of these comments were extremely positive. They commented that they were impressed with the practice and that they could always see a GP or a nurse when they needed to. One patient indicated that they had found their experiences at the practice less positive and felt they had not been listened to by their GP. We were unable to discuss this comment further with the patient as information was not provided to enable us to do so.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

We looked at the national GP Patient Survey dated 2013 and found that patients were generally satisfied with the appointments system. Data showed that 88% were satisfied with appointment times; 91% described their experience of making an appointment as good; and 93% would recommend this practice to someone new to the area. All these results were above the national average.

Areas for improvement

Action the service SHOULD take to improve

The practice should:

- Ensure all GPs complete infection control training including regular updates as required.
- Ensure that all GPs can be assured that all referral letters contain accurate information prior to correspondence being sent to consultants.
- Ensure clinical meetings are formalised and minutes kept, particularly when guidelines are updated to ensure that the whole clinical team are aware of current best practice.

St Johns Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP specialist advisor. The team also included an Expert by Experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to St Johns Surgery

St Johns Surgery is located in Bromsgrove in Worcestershire and provides primary medical services to patients. St Johns has a branch surgery at Wychbold but we did not inspect the branch surgery at this time. We focussed on the main surgery for this inspection. St Johns Surgery has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice covers Bromsgrove and Wychbold areas.

St Johns Surgery is an approved GP training practice for registrars. Fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP. The practice also teaches undergraduate medical students from the University of Birmingham. Patients have the option to see the trainees. Every consultation with a medical student is reviewed by a GP.

The practice has three male and three female GP partners, a practice manager, three nurses, one nurse practitioner who has extended duties such as prescribing certain medicines and referring patients for tests; a pharmacist, two healthcare assistants, administrative and reception staff. There were 11523 patients registered with the practice at the time of the inspection. The practice is open on Mondays from 8am to 6.30pm Monday to Friday. Extended hours appointments are available for both early mornings and late evenings, with some Saturdays for pre-booked appointments. The practice website tells patients these appointments are to assist the working population. Home visits are available for patients who are too ill to attend the practice for appointments.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as disease management clinics which includes asthma, diabetes, heart disease and stroke and mental illness. It offers child immunisations, minor surgery, family planning, and shared care drug services. Practice nurses can be seen by appointment for blood tests, ear syringing, dressings, injections, travel (including yellow fever) and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health advice. The practice does not provide an out of hours service but has alternative arrangements in place for patients to be seen when the practice is closed.

Why we carried out this inspection

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

This provider had not been inspected before and that was why we included them.

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

Before our inspection of St Johns Surgery, we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Redditch and Bromsgrove Clinical Commissioning Group (CCG), the NHS England area team to consider any information they held about the practice. We spoke with the managers of three of the five care homes supported by the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 21 November 2014. During our inspection we spoke with a range of staff that included three GPs, the practice manager, a nurse practitioner, two nurses, a health care assistant and three reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with six patients. We reviewed seven comment cards where patients and members of the public shared their views and experiences of the practice.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff told us they were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw that significant events had been discussed at practice meetings over the last year which demonstrated the willingness by the practice to report and record incidents.

We reviewed safety records and incident reports for the past three years. These records showed that the practice had managed these consistently over time and could evidence a safe track record over the longer term. We found that the practice had a standard form for recording incidents and staff demonstrated the ease of access they had to this should they need it.

Discussion with the registrars (qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP) and receptionists made it clear they would feel confident to report any concerns.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of significant events that had occurred during the last 12 months and were able to review these.

We found that significant events had shown who had reported these events. The date for review or follow up on progress had been recorded, with details of action taken where completed. For example, we saw where blood tests results had been recorded against the wrong patient during 2013. We saw that action had been taken to correct this. Alerts had been added to patients' notes where they had the same names to ensure risks of this recurring were reduced. We saw another incident in 2014 where monitoring of a patient who had been prescribed a specific medicine had been missed. As a result of this a safety improvement had been made and the maximum number of repeat prescriptions for this medicine had been introduced to ensure all patients received appropriate reviews of their medicines.

Significant event discussions were a standing item on the weekly practice meeting agenda. If necessary these were included for further discussion at the quarterly practice meetings which were attended by GPs, the practice manager and a nurse. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Reception staff told us they would report incidents when they occurred to their manager, who would then escalate these.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by the practice pharmacist by email to practice staff. Staff we spoke with confirmed this process. They told us that alerts were discussed at practice and clinical meetings. This ensured everyone was aware of any issues relevant to the practice and what action, if any, needed to be taken. We saw that any action taken had been recorded appropriately.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to advanced level and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm.

Patients' individual records were written and managed in a way that helped to ensure their safety. Records were kept on an electronic system called EMIS, which collated all

communications about the patient including scanned copies of communications from hospitals. We saw that the system was used to highlight vulnerable patients and ensured that staff were alerted to any relevant issues when patients attended appointments. GPs appropriately used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated effective working relationships with partner agencies such as health visitors, the police and social services.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consultation rooms. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Staff told us that chaperone duties were mainly carried out by clinical staff. We found however, that some reception staff had acted as chaperones, especially during extended hours when clinical staff had not been available and where patients had requested this. Reception staff confirmed they had not received formal training for this, although they were able to demonstrate an understanding of their role and responsibility as a chaperone. We discussed this with clinical lead and practice manager and they assured us that arrangements would be made to provide formal training for reception staff, within the next two months.

Medicines Management

We saw that the practice had policies and procedures in place for the management of medicines dated November 2014. This included medicines management and safe storage of vaccines. Staff told us they were aware of these policies and procedures and confirmed they were able to access these as required. There was a protocol for repeat prescribing which was in line with national guidance. We saw this was followed in practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank prescription forms and prescription pads were tracked through the practice and kept securely at all times. The practice had a process in place to limit the number of repeat prescriptions to ensure that patients' medicines were regularly reviewed.

Nurses and the health care assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines. For example, we saw that directions for the administration of flu, diphtheria, tetanus and shingles vaccines had been signed by the nursing staff.

A member of the nursing staff was qualified as an independent prescriber. This nurse was specially trained to prescribe any licensed and unlicensed drugs within their clinical competence. The nurse confirmed that they received regular supervision and support in their role. They also confirmed they kept up to date with the specific clinical areas of expertise for which they prescribed. Other nurses we spoke with confirmed that training was provided to ensure they kept up to date with their clinical expertise, knowledge and skills. We saw training records that supported this.

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

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

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. We saw from the comment cards that patients always found the practice clean and had no concerns about cleanliness or infection control. Hand hygiene technique signs were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw hand sanitation gel was available for staff and patients throughout the practice including the reception area.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example,

personal protective equipment including disposable gloves, aprons and coverings for couches were available for staff to use. Staff described to us how they used these in order to comply with the practice's infection control policy.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice's infection control policy and carry out staff training. We saw records that showed staff had received induction training about infection control specific to their role and thereafter annual updates. Staff we spoke with confirmed this. We found that not all GPs had completed infection control training. This was confirmed in records we looked at. The infection control lead told us this had been raised with the GPs and arrangements for this training to be completed were being made.

We saw evidence that the infection control lead had carried out regular audits and that any improvements identified for action were completed on time. We saw that the most recent audit had been carried out in October 2014. We saw from practice meeting minutes that the findings of this audit had been discussed which included that GPs had not completed infection control training. We also saw evidence that an infection control annual review had been carried out for 2014 which detailed results of all audits and progress where actions had yet to be completed.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff what to do in the event of a needle stick injury. Staff confirmed to us that they knew what action to take in the event they or a colleague sustained such an injury. We saw clear guidelines displayed in the treatment rooms to guide staff in such a situation. We saw evidence that staff had received the relevant immunisations and support to manage the risks of health care associated infections. Staff confirmed that they kept their immunisations up to date.

The practice had policies and systems in place to protect staff and patients from the risks of health care associated infections. We saw a risk assessment had been completed by an external company in June 2014 and had established the protocols to be followed in the building. For example, we saw that there was a water flushing protocol in place for the management of Legionella (a germ found in the environment which can contaminate water systems in buildings). This included flushing through showers that were not frequently used. Records were kept to show that these checks had been done.

Equipment

Staff told us they had equipment available so they could carry out diagnostic examinations, assessments and treatments. They told us that equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that portable electrical equipment was clearly labelled and dated to show it had been tested in March 2014 by an external contractor.

We saw records that confirmed measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order. For example, we saw that calibration (testing for accuracy) of relevant equipment such as weighing scales, nebulisers and blood pressure monitoring machines had been carried out in March 2014.

Staffing & Recruitment

Recruitment and selection processes were in place to ensure that staff were suitable to work at the practice. We saw a policy which outlined the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice.

We saw that Disclosure and Barring Service (DBS) checks had been completed for all staff who worked at the practice. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable.

Patients were cared for by suitably qualified and trained staff. There was a system in place that ensured health professionals' registrations were in date. We looked at a sample of recruitment records for clinical and administrative staff. These showed that pre-employment checks had been done to ensure that clinical staff held up to date qualifications with their governing bodies, such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). This ensured that GPs and nurses were registered with their appropriate professional body and were considered fit to practice.

Good

Are services safe?

We spoke with staff about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We saw evidence of cover arrangements that occurred during the inspection, which included clinical staff supporting and providing cover for each other with appointments.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy in place. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice building was managed by a separate company and was shared with another local practice. The building management company undertook annual and monthly checks of the building and the environment. The practice had access to these records so that they were given an overview of the checks completed. We looked at records that confirmed these checks had taken place. For example, we saw that the fire system had been inspected by an external contractor quarterly, and the most recent check had been done on 29 October 2014. A fire risk assessment had been completed in November 2013.

Identified risks were discussed at GP partners' meetings, within team meetings and shared with all staff by email. For example, the infection control lead confirmed that they would cascade information to all staff by email to implement any changes identified through audits. We saw that the last audit of infection control had been carried out in October 2014 and the findings and action plan resulting from this had been shared with staff. Staff we spoke with confirmed this.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. GPs told us that the practice receptionists were not required to triage patients for appointments as there were enough appointments available for all patients. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they failed to attend.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed all staff had received training in basic life support. Staff confirmed they knew how to respond to a medical emergency should one occur. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. Staff confirmed that any instances where emergencies had occurred would be discussed at the practice's significant event meetings.

We saw that panic buttons to call for assistance were fitted in all treatment and consultation rooms, and at reception desk. The lead GP told us that the practice building had a separate entrance which could be used to separate patients and staff in the event of a serious infectious outbreak. The building was designed in such a way that containment would be easily managed if the need arose.

We saw that a policy for emergency medicines and equipment was in place, dated November 2014. The policy detailed the location of the medicines and equipment. We saw that emergency medicines were available in the treatment rooms. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff were able to tell us where these were kept.

The practice had carried out a fire risk assessment in November 2013 which gave details of actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire

Good

Are services safe?

drills. The provider may wish to note however that staff training had not been completed since 2012 in line with best practice. We saw risk assessments had been completed for risks associated with spillages, contamination and disposal.

There were systems in place to respond to emergencies and major incidents within the practice. Risks identified included power failure, loss of main surgery building, loss of medical records, staff shortage and access to the building. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of a heating company to contact in the event of failure of the heating system, and utility services such as electricity and water suppliers. We saw there was an escalation procedure in place to protect computerised information and records should there be a computer systems failure. Pictorial guidance was displayed in treatment rooms so that staff could respond swiftly should an incident occur. The practice manager and GPs confirmed that copies of this plan were held off site with designated management staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). GPs demonstrated that they followed local commissioners' protocols regarding clinical decisions such as changes in care pathways. We saw copies of protocols in place for the treatment of diabetes, epilepsy and asthma reviews that had been updated throughout 2014. These were available through the practice computer system and on hard copies.

We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and for patients were discussed and any required actions were agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given the support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they keep up to date with current practice, evaluate the quality of their work and gain feedback from their peers. We saw evidence that all GPs had completed appraisals during 2014 apart from one who was due to complete an appraisal during November 2014. GPs told us they had also used 360 degree feedback to inform their appraisals. 360 degree feedback is a system or process in which employees receive confidential, anonymous feedback from the people who work with them, and patients who use the practice.

GPs told us they each led in specialist clinical areas such as diabetes, joint injections, respiratory disease, heart disease, mental health, and drug and alcohol use. The practice nurses supported this work, which allowed the practice to focus on specific conditions. The nurse practitioner confirmed that they only prescribed for their specialist areas that included diabetes, allergies and minor illnesses, gynaecology, family planning and contraception.

Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

The practice manager and lead GP described the screening programme they planned to carry out in the near future for all patients aged 80 and over who were not on the practice register. Assessments would be carried out to ensure patients who may have undiagnosed conditions received the care and support they needed which in turn would reduce unplanned hospital admissions.

Each patient over 75 years had a named GP; this included patients who lived in the care homes who were registered with the practice. We spoke with representatives from three of these care homes. They confirmed that needs assessment care plans were completed when required. They told us weekly visits were made by one of the GPs. They told us this was a good practice and that the GPs worked with the staff at the homes to ensure patients' needs were met at all times.

The practice met the Quality and Outcomes Framework (QOF) targets and achieved 91% compared with the CCG area average of 86% for mental health care plans. QOF is a national performance measurement tool. GPs told us that patients with mental health concerns received reviews of their physical and mental health, medicine and revision of their care plan annually. The practice also undertook the recommended health checks for patients with a learning disability. We saw patient records which confirmed this.

The practice used the gold standard framework (GSF) for managing terminally ill patients. The GSF is a practice based system to improve the quality of palliative care in the community to enable patients to receive support and dignified end of life care where they choose.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice made sure that patients were referred on need and that age, sex and race was not taken into account in this decision-making process.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). For example, we saw audits regarding the treatment of high blood pressure, and the long term use of medicines for osteoporosis (thinning of the bones). Following the audits, the GPs carried out medicine reviews for patients and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. We saw evidence that showed the findings of these audits had been discussed at practice meetings and actions taken had been recorded. Both these audit cycles had been completed. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The practice nurse told us they had carried out cervical screening audits and these were reviewed by senior clinical staff. Clinical staff told us audits were done and were discussed at practice meetings. They gave examples of infection control and minor surgery infection audits. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff confirmed that they followed this protocol. They told us they regularly checked that patients receiving repeat prescriptions had been reviewed by a GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP prescribed medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question. Where GPs had continued to prescribe such medicines, they had outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Staff employed at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training in areas such as basic life support and safeguarding adults and children. A good skill mix was noted amongst the GPs. GPs had additional interests in areas such as diabetes, asthma, heart disease, palliative care, safeguarding, dermatology and minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a more detailed assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

We saw records that confirmed staff had received annual appraisals. We saw that action plans had documented each person's identified learning needs and future objectives had been set. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors (registrars) who were in training to become qualified as GPs were offered extended appointments and had access to a training lead GP for support throughout the day.

Registrars who worked at the practice told us that they had received a thorough, clear induction and were very well supported. They told us they had no hesitation in taking any concerns to one of the GP partners either during or after a consultation, whichever was appropriate. They had an appropriate understanding of child protection procedures and consent. The registrars gave positive feedback about the practice.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, blood tests, ear syringing, dressings, injections, travel and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health

Good

Are services effective?

(for example, treatment is effective)

advice. Those with extended roles were trained in the diagnosis and management of patients with complex medical conditions such as diabetes and respiratory disease.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post.

The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP who saw the documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within the last year of any results or discharge summaries which had not been followed up appropriately.

The practice held multidisciplinary team meetings every six to eight weeks to discuss the needs of complex patients, such as those with end of life care needs or children who were considered to be at risk of harm. These meetings were attended by district nurses, health visitors and palliative care nurses and decisions about care planning were documented in a shared care record. Staff told us this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We spoke with the managers from three of the five care homes whose patients were registered with the practice. They told us the practice carried out regular weekly visits to the homes. They also confirmed that the GPs would attend outside these arrangements if necessary and responded promptly to any concerns they had.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system (EMIS) was used by all staff to coordinate, document and manage patients' care. All staff were trained in using the system. The use of the record system was also discussed at clinical patient care meetings to ensure a consistent approach in the use of these records by clinical staff. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We saw that referral letters were dictated by GPs and then typed by secretaries in order of urgency. We found that these letters were not being checked for accuracy by clinicians before they were sent. We discussed this with the lead GP and the practice manager. They confirmed they could not be assured that adequate accurate information was contained in the referrals as they were not checked prior to sending.

Patients registered with the practice had been encouraged to sign up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out of hours with faster access to key clinical information. Information about these was available for patients on the practice website, with a form to enable patients to opt-out from having a Summary Care Record if they chose.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act (2005), and assessment of Gillick competency of children and young adults. Gillick competency helps clinicians to identify children under 16 years of age who have the capacity to consent to medical examination and treatment.

Staff told us they completed Mental Capacity Act training through an on-line course. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff described how they would respond if a patient attended with a carer or relative. They told us they would always speak with the patient and obtain their agreement for any treatment or intervention, and if they thought a patient lacked capacity, they would ask their GP to review them.

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of records that confirmed care plans were in place and that reviews had been carried out.

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, we saw that verbal consent was documented for all minor surgical procedures. This was recorded in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw copies of completed consent forms which confirmed the consent process for minor surgery had been followed. We spoke with clinical staff who assisted GPs during minor surgery. They described the procedures they followed. These included obtaining consent during the initial consultation and reviewing this with the patient when they attended for minor surgery.

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

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurses. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews, offering smoking cessation advice to smokers, or to review the patient's long term condition.

The practice used numerous ways to identify patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. Similar mechanisms were in place to identify at risk groups such as patients who were likely to be admitted to hospital and those patients receiving end of life care. These patients were offered further support in line with their needs. The practice planned to commence screening of patients aged 85 and over who were registered with the practice but were not on the registers of health conditions. This was to ensure that patients received treatment should they have any undiagnosed condition.

Summary care reviews were provided by the practice for individual patients. This ensured that out of hours services and hospital services were able to access information about patients to assist in their treatment in the event of an emergency.

Up to date care plans were in place that were shared with other providers such as the out of hours provider and with multidisciplinary case management teams. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

The practice offered a full range of immunisations for children, travel vaccines (including yellow fever) and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was slightly higher than the average for the CCG, and again there was a clear policy and procedure in place for following up non-attenders by either the named practice nurse or the GP. Flu vaccination clinics were held every autumn. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse.

St Johns Surgery operated a patient carer protocol, to identify carers they could signpost to support agencies for help should they need it. The practice had carer support information available for patients in the waiting room which gave contact details for Worcestershire Association of Carers support group. Staff at the practice were also accredited 'dementia friends' to help to improve awareness and provide information for patients and carers.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey of 2013 and a survey of patients undertaken by the practice in 2013. The evidence from all these sources showed patients were satisfied that they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated among the best for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 88% were satisfied with appointment times; 91% described their experience of making an appointment as good; and 93% would recommend this practice to someone new to the area. All these results were above the national average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received seven completed cards and all but one was positive about the service experienced. Patients commented that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They noted that staff treated them well, politely and with respect. The less positive comment indicated that the patient felt they had not been listened to by GPs. We also spoke with six patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said that GPs had given them the time they needed and that staff spoke to them in a respectful way.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consultation room. Curtains were provided in consultation rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff confirmed they ensured patients' dignity was maintained by making sure the door was closed and that screens were used to enable patients to undress in private. Patients were made comfortable and staff told us they offered a chaperone service if patients preferred. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them. We saw leaflets in the reception area and information on the practice website that confirmed this.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with one of the managers. Staff told us incidents would be investigated and this information and any learning would be shared with staff. We saw minutes of staff meetings that had taken place which showed that incidents had been discussed and learning identified.

We spoke with the managers of three care homes supported by the practice. They described to us the caring, professional, supportive attitude of everyone who worked at the practice from GPs, to nursing and reception staff. They told us they had no hesitation in contacting the GPs should they need to and they confirmed that a GP would attend as required.

There was a clearly visible notice in the patient reception area and on the practice's website informing patients of their zero tolerance for abusive behaviour. Receptionists told us they felt confident in responding to such incidents and that referring to the procedure had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from the national patient survey 2014 showed 81% of practice respondents said the GP and the nurses were good at involving them in decisions about their care which was in keeping with the national average.

Good

Are services caring?

Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that the patient always came first and were always encouraged to be involved in the decision making process. They described that they would always speak with the patient and obtain their agreement for any treatment or intervention even if a patient attended with a carer or relative. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community to enable patient to receive support and dignified end of life care where they choose.

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

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with during the inspection and the comment cards we received were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the practice website also signposted people to a number of support groups and organisations. The computer system used by the practice alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

We saw that the practice worked to the Gold Standard Framework (GSF) for palliative care. We saw that regular multi-agency and cross practice meetings were held and recorded. End of life care and bereavement information was available to patients and their relatives/carers in the waiting rooms. This included information to advise patients what to do if a death occurred at home or in hospital. Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or signposting to a support service. The managers of the care homes told us that GPs always gave support where it was needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people'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. For example, the practice had committed to providing services to the wider community through the virtual ward scheme. A virtual ward is a term used for providing support in the community to people with the most complex medical and social needs.

Virtual wards use the systems and staffing of a hospital ward, but without the physical building: they provide preventative care for people in their own homes. Virtual wards are split into three categories; red for the management of acutely ill patients within a community environment; amber for the management of patients with increased therapy and rehabilitation needs; and green for the proactive management of patients identified to be at risk of unplanned hospital admissions. St Johns Surgery had committed to the red ward which meant they would be meeting the needs of patients within the wider community in general and not only to patients registered with their practice. GPs told us this meant they worked with other practices as well as hospitals in responding to patients with complex medical and social needs.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions.

Longer appointments were available for patients who needed them such as patients with mental health, learning disabilities and long term conditions. Patients were also given appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week. Additional visits were made to those patients who needed a consultation outside of these routine visits.

Tackle inequity and promote equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for an interpreter if required and that information could also be translated via the internet. The practice's website offered translation of information into 80 languages for patients.

Female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

The practice provided equality and diversity training through e-learning. Clinical staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was discussed at staff team meetings. We saw records that showed the GP lead had completed equality and diversity training.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included

Good

Are services responsive to people's needs?

(for example, to feedback?)

details on how to arrange urgent appointments, 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. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website.

The practice was open on from 8am to 6.30pm Monday to Friday. Extended hours appointments were available for some early mornings and late evenings, with some Saturdays for pre-booked appointments. The practice website explained to patients that these appointments were made available for the working population. Home visits were available for patients who were too ill to attend the practice for appointments. Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to five local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

The practice building was accessible to patients. The practice operated from the newly purpose built medical centre which had opened in May 2011. The building had been designed to meet the requirements of disabled patients and patients with special needs. The practice operated over two floors with lift access. The practice building was large, with wide corridors for patients with mobility scooters to move freely around the building. Patients were able to move around the building independently. Facilities included two lifts, disabled toilets, onsite physiotherapy, dentist, pharmacy, optician and free disabled parking.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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.

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions had been taken to resolve each complaint as far as possible. We tracked three complaints and found these had been handled in line with the practice's policy with learning identified where appropriate.

We saw that nine complaints had been logged for the previous 12 months. The modes of complaint included verbal, e-mail, phone calls, letters as well as those where complaint forms had been completed. This indicated patients knew how to complain and all complaints were looked and actioned however serious or otherwise they were. For example, we saw a complaint from a patient that had been investigated. A written explanation had been sent to the complainant and included other agency contact details should the patient have wished to take their complaint further. We saw that no further action had been required.

Accessible information was provided to help patients understand the complaints system on the practice's website and in the practice's leaflet. Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of the patients had ever needed to make a complaint about the practice. Staff told us they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. Evidence showed that lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients through 'opening doors to superior healthcare'. The GP partners told us that they placed importance on the welfare of the staff that worked for the practice with an emphasis on a work/life balance for all.

The practice vision and values included providing a safe, effective, caring and responsive service of the highest quality to all their patients. This included the practice's aim to provide as wide a range of services as was possible on their own premises in ways that encouraged access by all their patients.

The practice aimed to work collaboratively with all other sections of the local healthcare system to ensure their patients received the highest standard of seamless care. Staff we spoke with knew about and understood the vision and values for the practice. They knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at seven of these policies and procedures. We saw plans were in place to ensure these were reviewed annually or sooner if required.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a national performance measuring tool. The QOF data for this practice showed it was performing in line with and above national standards. For example, data showed that the practice achieved a total 100% QOF points compared with the national average of 96% in 2013. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits which included audits for medicines prescribed for mood disorders and medicines prescribed to prevent the loss of bone mass. Following the audits the GPs carried out reviews for patients who were prescribed these medicines and altered their prescribing practice in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. We found that the practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as spillages. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for risks such as needle stick injuries.

Leadership, openness and transparency

There was a clear, visible leadership and management structure in place with responsibility for different areas shared amongst GP partners. There was a practice manager and deputy practice manager in post. The staff were organised into medical, nursing and reception teams. They operated as separate teams linked by managerial input.

Named members of staff had lead roles. For example, there were clinical leads for asthma, lung disease, chronic kidney disease, diabetes, women's health, cardiovascular (heart) medicine, minor surgery, dermatology (skin), palliative care and safeguarding. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Staff felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us they felt very much supported by all partners of the practice.

Staff told us that there was a positive, open culture and focus on quality at the practice. Staff told us they had the opportunity and felt comfortable to raise any issues at team meetings. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. The practice managers told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs

Are services well-led?

Good

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

and practice managers were very supportive. GPs and registrars also confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. Staff told us they were happy to work at the practice, that everyone worked well together and they were well looked after. They shared the ethos of the practice that if staff were happy at work they would reflect this in their work at the practice.

The practice building had been 10 years in the making and was a joint venture with another practice who also shared the building. The capability of the leadership team was evident in the design of the practice's new premises and the organisation within it. The building was practical in design and enabled a wide range of services to be provided. For example, the building layout and alternative access would facilitate segregation of patients and staff in the event of an infectious outbreak.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction policy, recruitment and equal opportunities policy which were in place to support staff. Staff told us there was a staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required. Succession planning was managed by sharing the managerial responsibility between the partners.

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

The practice had gathered feedback from patients through patients' surveys which had been completed during 2013 and from complaints received. The practice had an active virtual patient participation group (PPG). Membership of this group was available to all patients on the practice's website for them to complete questionnaires and give their views about the practice. Staff told us the practice shared the survey results with the whole team for discussion at a staff meeting. This gave staff the opportunity to give feedback on any of the findings from the survey report. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

We saw from minutes that staff meetings usually took place every two months. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us the practice had recently acted following feedback from the patients regarding the option to speak to the receptionists away from the reception area. A poster was displayed on the reception desk to remind patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff confirmed they knew who to talk with in the event they had any concerns.

Management lead through learning & improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

We found however that minutes of all meetings had not been kept and therefore had not provided evidence or an audit trail of the discussions that had taken place. For example, There was no recorded evidence of formal clinical meetings chaired by clinical leads to review recent guidelines and best practice, although we were told that evening clinical meetings had been held as needed.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated

Are services well-led?

Good

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

and actioned. For example, we saw that significant event reporting had been discussed at the practice meeting held in September 2014. We saw that the details of the incident, who was involved, and action taken had been discussed.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that they had regular protected time provided for learning. Staff told us that information and learning was shared with staff at practice meetings.

The practice was a well-established GP training practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with the practice's current GP registrars. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team.