Brickfields Surgery

Quality Report

4 Brickfields Road, Chelmsford, Essex
CM3 5XB
Tel: 01245 328855
Website: www.brickfieldssurgery.co.uk

Date of inspection visit: 25 March 2015
Date of publication: 23/04/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	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 conducted a comprehensive announced inspection on 25 March 2015

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 the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings 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, addressed and shared with staff during meetings.
- Risks to patients and staff were assessed and managed. There were risk management plans in which included areas such as premises, medicines handling and administration, infection control and safeguarding vulnerable adults and children.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles. Staff were supervised and supported as needed and any further training needs had been identified and planned for.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. They told us that access to appointments with GPs and nurses was good and that they were happy with the treatments that they received.
- Information about services and how to complain was readily available and easy to understand. Complaints were handled and responded to in line with relevant guidelines.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However, there were three areas of practice where the provider needed to make improvements.

The provider should

- Ensure that infection control audits in relation to minor surgical procedures are carried out to monitor incidents of infections and identify an infection control lead for oversight of infection control procedures within the practice.
- Ensure that staff who undertake chaperone duties undertake appropriate training in respect of this role.
- Carry out clinical audit cycles to monitor and improve, where needed, outcomes for care and treatment.

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. When things went wrong these were investigated to help minimise recurrences. 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. Patients, including children, who were identified as being at risk were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe.

Premises were clean and risks of infection were assessed and managed. However infections associated with minor surgical procedures were not assessed or monitored. The practice had suitable equipment to diagnose and treat patients and medicines were stored and handled safely.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were generally average for the locality and where there were areas for improvement the practice was proactive in dealing with these. Staff referred to guidance from National Institute for Health and Care Excellence which was used routinely to improve care and treatment outcomes for patients. Patients' needs were assessed and care was planned and delivered in line with current legislation. Clinical audit cycles were not used to monitor treatments and clinical procedures.

Patients' general health was monitored through health screening checks and patients with long-term medical conditions were reviewed annually to assess and monitor their conditions and ensure that the treatment they received was appropriate. The practice provided a range of health promotion advice and sessions including smoking cessation clinics and advice on healthy diet and lifestyle choices.

Staff had received training appropriate to their roles, where further training needs had been identified there were plans to meet these needs. Staff were supervised and their performance was appraised each year. Staff worked with multidisciplinary teams to ensure that patients received effective care and treatment.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data from patient surveys showed that patients rated the practice higher than others for several aspects of care, such as how GPs and nurses explained their care to them and were good at listening to them. 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 accessible and easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We received positive remarks on the comment cards about the care people experienced at the practice, and the people we spoke with during the inspection confirmed this.

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 the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The majority of patients at the practice were in the working age group. The practice had adapted its appointment to meet the needs of these patients by offering early morning appointments and telephone consultations. Emergency walk in appointments were available each morning.

The majority of patients said they could make an appointment with a named GP and that there was continuity of care, with emergency appointments available the same day. The practice made adjustments to the premises to meet the needs of patients with mobility difficulties. The practice did not have lift access to the first floor consultation and treatment rooms. Patients who were identified as requiring an appointment on the ground floor had their records maintained to ensure that they were accommodated in rooms on the ground floor. The practice was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and staff knew their responsibilities in relation to this.

Summary of findings

The ethos within the practice was to provide high quality care and treatment within a friendly and caring environment. Staff demonstrated that this was reflected in the care and treatment provided to patients.

There was a clear leadership structure and staff told us they felt supported by management. Staff said that the practice management were open and responsive to suggestions for improvement. They told us that they were involved in discussions and decision making as to how the practice was managed.

The practice had a number of policies and procedures to support staff and to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

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

This practice is rated as good for the care of older people. Patients over the age of 75 years had a named accountable GP who is responsible for their care and treatment. The practice identified patients who were at risk of avoidable unplanned hospital admissions. These patients were included on the practice's 'unplanned admissions avoidance' list to alert staff to people who may be more vulnerable. The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments. The practice provided a range of health checks for patients aged 75 years and over. Seasonal flu vaccination and shingles vaccination programmes were provided. Flexible appointments were provided, including longer appointments if needed and early morning appointments from 7.30am three mornings each week. The practice also offered walk in appointments for urgent treatment between 9am and 11.30am each day. Patients with one or more long-term medical condition in the over 75 years population group and those who were identified as being vulnerable were included on a frailty register and had individualised care plans, which were reviewed every three months by the patient's named GP.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual and half yearly reviews of their health and medication to ensure that their treatment remained effective. Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. 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.

Summary of findings

Patients had access to early morning appointments from 7.30am three mornings each week and daily walk in appointments were available for urgent treatments between 9am and 11.30am each day. Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be booked in person or by telephone. Appointments could be booked up to four weeks in advance.

Information and advice was available to promote health to women before, during and after pregnancy. A full range of pre-conception, antenatal and postnatal care services was available with the community midwife with fortnightly appointments and clinics. The practice monitored the physical and developmental progress of babies and young children. Appointments were made available outside of school hours wherever possible.

There were arrangements for identifying and monitoring children who were at risk of abuse or neglect. Records showed that looked after children (such as those in foster care / under the care of the Local Authority), those subject to child protection orders and children living in disadvantaged circumstances were discussed, including any issues shared and followed up, at monthly multi-disciplinary meetings. GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group 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. Appointments could be booked online, in

person or by telephone. Appointments could be booked up to four weeks in advance. Appointments were available from 7.30am three days each week and walk in clinics were available from 9am to 11.30am each day for urgent care and treatment.

Information about annual health checks for patients aged between 40 and 75 years was available within the practice and on their website. Nurse led clinics were provided for well patient health checks. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the various vaccinations available including diphtheria, tetanus, polio and hepatitis A was available on the practice website. When patients required referral to specialist services, including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of patients who had learning disabilities. All patients with learning disabilities were invited to attend for an annual health check. The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. 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 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 population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

Patient referrals were made to appropriate services such as psychiatry and counselling, including The Improving Access to Psychological Therapies (IAPT) and referrals to child and adolescent Mental Health Services (CAMHS).

Summary of findings

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. Patients were referred to local counselling sessions where appropriate and patients were provided with information how to self-refer should they wish to receive counselling.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at eight CQC comment cards patients had completed for us. The responses we received were overwhelmingly positive about the care and treatment they received and the kindness of staff at the practice. All patients who completed comment cards reported the ease of accessing appointments at the practice, that they could be seen on the day and that they did not have to wait long for pre-booked routine appointments.

We also spoke with four patients. Many patients who gave us their views in person and through completing our comment cards had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Data available from the NHS England GP patient survey showed that the practice scored in the upper range nationally for patient satisfaction with the practice. We reviewed the results from the 2014 National GP survey in which 93% of patients who participated would recommend the practice. The majority of patients reporting satisfaction with: the practice opening hours, access to appointments, the way they were treated by staff, involvement in decision making and feeling listened to.

Areas for improvement

Action the service SHOULD take to improve

The provider should

- Ensure that infection control audits in relation to minor surgical procedures are carried out to monitor incidents of infections and identify an infection control lead for oversight of infection control procedures within the practice.
- Ensure that staff who undertake chaperone duties undertake appropriate training in respect of this role.
- Carry out clinical audit cycles to monitor and improve where needed outcomes for care and treatment.

Brickfields Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a two CQC inspectors and a GP specialist advisor.

Background to Brickfields Surgery

Brickfields Surgery is located on the town of South Woodham Ferrers, which is geographically situated within the borough of Chelmsford. The practice provides services for approximately 6,000 patients living in the town. The practice holds a General Medical Services (GMS) contract and provides GP services commissioned by NHS Mid Essex Clinical Commissioning Group.

The practice is managed by one two GP partners who are supported by clinical staff; two salaried GPs, one advanced nurse practitioner, three practice nurses, one healthcare assistant / phlebotomist. The practice also employs a practice manager, a business manager and a team of reception, clerical and administrative staff. The practice also employs a cleaner.

The practice is open from 7.30am to 6.30pm on weekdays. GP and nurse appointments are available from 7.30am on Mondays, Tuesdays and Wednesdays. Daily walk in clinics for urgent care and treatments are available daily from 9am to 11.30am. Routine appointments can be pre-booked up to four weeks in advance in person, by telephone or online. Home visits and telephone consultations are available daily as required.

The practice has opted out of providing GP services to patients outside of normal working hours such as evenings and weekends. During these times GP services are provided by Primecare Primary Care, an out-of-hours advice, emergency and non-emergency treatment service. Details of how to access out-of-hours advice and treatment is available within the practice, on the practice website and in the practice leaflet.

Why we carried out this inspection

We inspected Brickfields Surgery 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:

- Is it safe?
- Is it effective?

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 March 2015. During our visit we spoke with the GP partners, practice and business managers, one practice nurse, the phlebotomist / Healthcare assistant and reception staff. We spoke with five patients who used the service. Were viewed documents and records relating to the management of the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety including incidents, comments, complaints and national patient safety alerts. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts contained safety and risk information regarding medication and equipment, often resulting in the withdrawal of medicines from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. From the minutes of practice meetings, communicated emails to staff and through discussion with staff we saw that information was shared with staff so as to improve patient safety.

Complaints, accidents and other incidents such as significant events were reviewed regularly and discussed at practice meetings to monitor the practice's safety record and to take action to improve on this where appropriate. Staff we spoke with could give examples of learning or changes to practices as a result of complaints received or incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Through discussions with staff and a review of records we saw that accidents, significant events and any other safety incidents were fully investigated. A root cause analysis was carried out to determine where improvements could be made and to identify learning opportunities to prevent recurrences. We saw that incidents and significant events were discussed with staff at regular meetings and on an individual basis as needed. Where areas for improvements were identified these were reviewed to help ensure that learning was imbedded into the practice. Staff we spoke with could give examples of where practices had changed following investigations of significant events, concerns and complaints.

Staff we spoke with told us that the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Practice training records made available to us showed that all staff had undertaken relevant role specific training on safeguarding adults and children. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had a designated lead for safeguarding vulnerable adults and children who had oversight for safeguarding within the practice. From training records viewed we saw that the lead had undertaken appropriate safeguarding training, including level 3 safeguarding children training. Staff we spoke with knew who the lead was and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information making staff aware of any relevant issues when patients attended or failed to attend appointments; for example, looked after children or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed at weekly GP meetings and monthly multidisciplinary team meetings, which were attended by health visitors, district nurses and school nurses. We looked at the records from these meetings and found that information was shared with the relevant agencies, reviewed, followed up and appropriate referrals were made as required. The practice had participated in a local Clinical Commissioning Group (CCG) audit around safeguarding children and young people in 2014 to ensure that safeguarding procedures within the practice were robust and referrals were made and followed up

appropriately. The audit showed that the practice was meeting the majority of outcomes and where areas for improvements had been identified these had been actioned.

A chaperone policy was in place and details about how to request a chaperone were visible in the waiting room. (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). The chaperone policy described the clinician's responsibilities for determining when a chaperone would be needed. The policy covered chaperoning a patient in their own home. Where a chaperone was deemed appropriate but unavailable consultations would be rescheduled unless in emergency situations, where to do so would adversely impact on the health of the patient. We saw that where patients were identified as requiring a chaperone this was recorded within the electronic patient records system so that staff were alerted when the patient visited the practice.

Chaperone duties were undertaken by dedicated nursing staff. The practice manager confirmed that staff had not undertaken chaperone training. From records viewed we saw that criminal records checks had been carried out with the Disclosure and Barring Service (DBS) for all staff working at the practice. Staff we spoke with were aware of their roles and responsibilities when acting as a chaperone during patient consultations. Patients we spoke with were aware that they could request a chaperone during their consultation, if they chose to.

Patients' individual records were kept on the practice newly installed electronic system which collated all communications about the patient, including scanned copies of communications from hospitals. We saw evidence that staff had undertaken training in the use of the electronic system and were able to use it to record and store information around patient safety and safeguarding vulnerable patients.

Medicines Management

Medicines were managed safely so that risks to patients were minimised. There were suitable arrangements for secure storage of medicines, including vaccines, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in the correct quantities and in date.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directives and evidence that nurses had received appropriate training to administer immunisations and vaccines.

The practice followed national guidelines around medicines prescribing and repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had robust arrangements for reviewing patients with long term conditions to ensure that the medicines they were prescribed were appropriate and that risks were identified and managed. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Staff told us that where patients who were prescribed medicines on a longer-term basis were monitored to ensure they were contacted for (and attended) their regular medication reviews. They told us that letters and text message reminders were sent and follow up calls made as needed.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed leaflets and posters. Patients could order repeat prescriptions in person, by fax, post or online through the secure clinical electronic system (SystmOne) (for patients who were registered for online access). Patients we spoke with told us they were given information, such as side-effects and any contra-indications, about prescribed medicines. They told us that the repeat prescription service worked well and they had their medicines in good time.

We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for some antibiotics was higher than the national average. National guidelines around the prescribing of these broad spectrum antibiotics suggested that they should be reserved for the treatment of resistant strains of infections and generic antibiotics should be used. We discussed this with the senior GP partner and they advised that the broad spectrum antibiotics were used in the treatment of prostate related infections as indicated, which accounted for the high usage. Data we reviewed

showed that prescribing of anti-inflammatory medicines (used in the treatment of inflammatory conditions such as arthritis) and sedatives and antidepressants were in line with national averages.

There was a system in place for the management of high risk medicines such as medicines used in the treatment of terminal and life limiting illnesses, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. There were arrangements in place for the handling and storage of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). We saw that these were stored securely and regularly checked.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. The practice had suitable procedures for protecting patients and staff against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice, as were posters promoting good hand hygiene. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had in place infection control policies and procedures for staff to follow, which enabled them to plan and implement measures for the control of infection. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. All clinical staff had undertaken infection control training and staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. All staff undertook regular hand hygiene training and staff were provided with appropriate personal protective equipment including gloves and aprons.

The practice employed a cleaner for general cleaning. We saw there were cleaning schedules in place for general and clinical areas. The practice nurses told us that they were responsible for cleaning the treatment room in between patient consultations. Nursing staff and the practice manager told us that regular visual checks were carried out on premises, equipment etc. to ensure that they were clean, however these were not recorded.

Through discussion with staff we found that the practice had not identified a lead for overseeing infection control measures. The practice manager assured us that this would be implemented. Records we viewed showed that infection control audits had been carried out to test the effectiveness of the general cleaning and infection control procedures within the practice. These audits demonstrated that the practice had robust systems in place for identifying and managing risks of infections. The practice carried out minor surgical procedures such as injections and skin excisions. These procedures were carried out in the practice treatment room. There were no audits of surgical procedures carried out to monitor post procedure infection rates. The senior GP told us that these audits would be carried out in the near future.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment (including blood pressure monitoring devices, scales and thermometers) was periodically checked and calibrated to ensure accurate results for patients.

We saw records showing that other equipment required for the safe running of the practice, including fire detecting and firefighting equipment was checked and replaced as required. Portable electrical equipment was portable appliance tested (PAT) annually. PAT testing is an examination of electrical appliances and equipment to ensure that they are safe to use.

Staffing & Recruitment

The practice had robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. The practice recruitment policy set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the records for five members, two of whom had been employed within the previous year. We saw evidence that appropriate recruitment checks had been undertaken prior to

employment. Employment references and criminal records checks were in place for each of the five members of staff. There were procedures in place for managing under-performance or any other disciplinary issues.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures or adverse weather conditions). Staff told us that they would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, of which staff were aware. We saw that a health and safety risk assessment had been carried out to help identify risks to staff and patients.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they aware of these procedures. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; they described how they would treat and escalate concerns about adults or children or a patient who was experiencing a physical or mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing all staff had received training in basic life support. Emergency medicines and oxygen were available in a dedicated place within the practice as were 'anaphylaxis kits' (containing medicines to treat severe allergic reaction). All staff who we asked knew the location of these medicines. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified key members of staff and their roles and responsibilities in identifying and managing risks to the provision of service from the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained details of the relevant people to contact in the event of any incident, which may disrupt the running of the day-to-day operation of the practice.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw that the fire safety and evacuation procedure was displayed at fire exits and throughout the practice waiting areas and corridors. Fire alarm tests were conducted weekly and details of these were displayed throughout the building. Staff we spoke with were aware of the procedures to follow in the event of a fire or other untoward event which would require the building to be evacuated.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information and new guidance were made available in information folders and shared with staff during regular meetings to ensure that practices were in line with current guidelines to deliver safe patient care and treatments.

We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance in assessing and treating patients with long term conditions such as asthma and chronic respiratory illnesses were generally in line with that the local Clinical Commissioning Group (CCG) averages. We saw that, where performance fell below the local or national averages, there were arrangements to make the necessary improvements. For example the practices' performance in relation to reviewing patients with diabetes was lower than expected. The practice manager explained that this was partly due to the times of the diabetic clinics, which were held during the afternoon and difficult for patients of working age to attend. In order to help address these issues the GPs told us that they had added appointments for reviews of patients to each surgery session and that this had increased the number of reviews of patients with diabetes.

The practice GPs and practice nurses took a lead role in specialist clinical areas such as learning disabilities, diabetes, heart disease and asthma. The practice nurses carried out reviews for patients with long term conditions and carried out well man and well woman checks through pre-booked appointments. This allowed the GPs to treat patients with more complex medical conditions.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management.

The practice did not have a system for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved.

We looked at the data and information we held about the practice. This included information taken from the voluntary Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was generally in line with the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as dementia, learning disabilities and mental health disorders. We saw evidence that where the practice scored below the national average, staff were proactive in making the necessary improvements. For example the practice scores for diabetes screening were lower than the average. We saw evidence that the GPs and practice nurse were proactive in following up on patients who had failed to attend appointments and they had made changes to the availability of appointments for these reviews, adding appointments to daily surgery sessions. The practice kept a register of patients who were receiving palliative care and treatment and were monitoring and planning care to ensure that patients received appropriate care.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

Effective staffing

The practice employed staff who were skilled and qualified to perform their roles. Appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and

training records for five members of staff. We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw that staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Staff we spoke with told us that the GP provided opportunities for learning and that they undertook a range of online and face-to-face training. Records we viewed confirmed this. All new staff underwent a period of induction to the practice. Support was available to all new staff to help them settle into their role and to familiarise themselves with relevant policies, procedures and practices.

Through discussions with GPs and a review of staff records we saw that 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 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).

Individual staff performance was assessed and training and development needs were identified through an annual appraisal system. Staff had personal development plans that detailed their planned learning and development objectives, which were kept under review. We saw that where staff had identified training interests arrangements had been made to provide suitable courses and opportunities. The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice and the support that they received. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had dedicated leads for overseeing areas such as safeguarding, palliative care and learning disabilities. The practice nurses had undertaken specific training in health promotion and the treatment of minor illness such as, acute asthma, smoking cessation and sexual health screening. The nurses provided services including well person checks, long term condition reviews, family planning and cervical screening. This enabled the doctors to focus on more complex problems and conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and support patients with complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patients care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out of hour's providers and the NHS 111 summaries were reviewed and actioned on the day they were received.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs including those with end of life care needs, and vulnerable families and children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses where decisions about care planning were documented in a shared care record. We looked at the records for the last four meetings and found that detailed information was recorded, reviewed and shared to ensure that patients received coordinated care, treatment and support.

The GP told us that they held regular meetings with the care home where they had patients. They told us that this helped to ensure good working relationships to improve outcomes for patients. The GP confirmed that the details of these meetings were not recorded and as such unavailable to view.

Information Sharing

The practice had systems in place to provide staff with the information they needed. The practice had recently introduced SystmOne, an electronic patient record to coordinate, document and manage patients' care. All staff had undertaken training on the system. GPs and nurses we spoke with told us that information was accessible to help them make decisions and to plan and deliver effective care and treatment.

There was a system for making sure test results and other important communications about patients were dealt with. These were passed to GP's to review and act on as required. The practice had systems for making information available to the 'out of hours' service about patients with complex

care needs, such as those receiving end of life care, vulnerable patients and those identified as at high risk of unplanned admission to hospital. We saw that treatment records for patients who had used the 'out-of-hours' service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment.

The practice maintained registers for patients with life limiting illnesses, those identified as vulnerable or frail and patients with mental health conditions or those with learning disabilities. GPs and nurses at the practice worked closely with Macmillan nurses and other agencies who support people with life limiting illnesses. They held a monthly palliative care meeting to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs. Regular multidisciplinary meetings were held to discuss patients' needs. Other health and social care professionals including district nurses, health visitors and social workers attended to help ensure that patients received coordinated care and treatments as needed.

Staff were alert to the importance of patient confidentiality and the practice had appropriate policies and procedures in place for handling and sharing patient information.

Consent to care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children. The nurse we spoke with told us that they obtained parental consent before administering child immunisations and vaccines.

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff we spoke with were aware of the Mental Capacity Act 2005 as it relates to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in the person's best interests.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health promotion and healthy lifestyle choices available within the waiting rooms, reception and entrance hall where patients could see and access them. We saw information about mental health, domestic violence advice and support that was prominently displayed in waiting areas with helpline numbers and service details. There was information and guidance available on diet, smoking cessation and alcohol consumption. There was information available about the local and national help, support and advice services. This information was available in written formats within the practice. Large print documents and information in languages other than English were available if needed.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 75 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check. Nurse led clinics and pre-booked appointments were available including sexual health, family planning and menopausal advice, heart disease prevention, diabetic and asthma clinics.

The practice's performance reviews for diabetes were lower than local and national averages. The practice acknowledged that there had been difficulties carrying out reviews, in part due to times of diabetic clinics, which were carried out in the afternoons. Staff were working proactively in following up patients who had not attended reviews; appointments for reviews had been added to daily clinics to help improve the uptake of reviews.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Information about the range of immunisation and vaccination programmes for children and adults was well signposted throughout the practice and on the website. Childhood immunisation clinics were held each Wednesday morning. Data we looked at before the inspection showed that the practice was performing in

Good

Are services effective?

(for example, treatment is effective)

line with the average of other practices in the area for take up of childhood immunisations. We saw that the GPs and practice nurse were working proactively to follow up patients who failed to attend appointments.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the eight CQC comment cards that patients had completed and spoke in person with four patients. The response from patients was overwhelmingly positive with all patients reporting that staff at the practice were helpful and good at listening to them. The patients who completed comment cards said they felt the practice provided consistent and excellent care and treatment.

We reviewed the most recent information available from the national patient survey, which was carried out in 2014. We saw that 93% of patients would recommend the practice and approximately 86% of patients reported that GPs and nurses were good at listening to them and treated them with care and concern. We also looked at the results of the 'I Want Great Care' Friends and Family Test, which patients completed regularly. We saw from the results of these that the practice had scored consistently high in the January and February 2015 responses. 100% of those who participated in the test in January 2015 said that they would be extremely, or very, likely to recommend the practice to friends and family and 96% reported the same in February 2015. Many patients who participated in the test commented very positively about the friendliness of staff and reported that they were treated with compassion and kindness.

Staff were aware of the practice's policies for respecting patients' confidentiality, privacy and dignity. Reception staff told us if patients wished to speak privately to a receptionist, they were offered the opportunity to be seen in another room. During the inspection we spent time in the reception area. This gave us the chance to see and hear how staff dealt with patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients.

There were signs in the waiting areas and consulting rooms explaining that patients could request a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish so. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting / treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a range of anti-discrimination policies and procedures and 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 the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patients' consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The results from the 2014 National Patient GP survey which we reviewed showed that patient's responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, approximately 79% of practice respondents said the GP was good at explaining treatment and results and that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that the GPs were caring, took their concerns seriously and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the

Good

Are services caring?

comment cards we received was also overwhelmingly positive and each of the eight patients who responded told us that they were happy with their involvement in their care and treatment.

The practice identified vulnerable patients and kept a register. The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older people, those living in care homes and vulnerable at risk patients. This monitoring identified patients most likely to have an unplanned admission to hospital. Where patients were identified as vulnerable, care plans were implemented, which were discussed and reviewed at multidisciplinary team meetings to help ensure that patients had appropriate support systems in place to help reduced unplanned admissions to hospital.

Staff told us that the vast majority of patients registered with the practice were English speaking. They told us that translation services would be made available for patients who did not have English as a first language. The practice had recently introduced an electronic appointment check-in system, which was set up to reflect the most common languages in the area. Staff had access to an interpretation and translation service.

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and carers were provided with information and support to access local services and benefits designed to assist carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Staff told us families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation at the practice or a home visit where this was more appropriate. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations who deal with emotional issues such as bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by Clinical Commissioning Group (CCG) targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities.

The facilities and premises coped with the services which were planned and delivered, with sufficient treatment rooms and equipment available. Some clinical staff were based on the first floor and the practice did not have a lift, therefore if patients with mobility limitations were to have an appointment with a GP/nurse from the first floor there were arrangements for a temporary swap with a GP from the ground floor to ensure patients were able to see the GP/nurse of their choice. This was recognised by the provider as a growing issue and the provider was actively engaged in sourcing new premises.

The appointment system was effective for the various population groups that attended the practice. The working age population were able to obtain appointments in the morning from 7.30am on Monday, Tuesday and Wednesday. Longer appointments were available for patients with learning disabilities, those suffering from poor mental health and those with long-term conditions or complex needs. Home visits were available for those with limited mobility or otherwise unable to get to the practice.

Vulnerable patients such as those with a drug and alcohol addiction or suffering with poor mental health were signposted to external organisations that could provide support to them. This included support from an organisation known as 'Changes' which offered a wide range of treatments.

Tackling inequity and promoting equality

The practice leaflet and mission statement promoted diversity and stated that patients would be welcomed without discrimination. Telephone or online translation services could be accessed where necessary. There was no hearing loop installed for those hard of hearing, however staff explained they dealt with this by taking patients into a private room or writing things down, which they felt promoted patient confidentiality.

The practice had registers of people who may be living in vulnerable circumstances and those with learning difficulties; staff were able to give examples of how these helped them deal sensitively with patients, for instance offering extra support to attend or longer appointments.

The premises and services had been adapted to meet the needs of patient with disabilities the entrance was accessible via a ramp and the practice had recently widened the entrance door to accommodate prams and wheelchairs.

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

Access to the service

Patients could make appointments by telephone, calling at the surgery, or online. Repeat prescriptions could be ordered online. The practice had extended its opening hours in response to increased patient numbers, and was open from 7.30am until 6pm three days a week and 8.30am to 6pm on two days a week this also helped patients access the service who worked during the day.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements 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.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes when requested.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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.

We saw that information was available to help patients understand the complaints system the practice manager handled written complaints but all staff were aware of the complaints procedure and would in the first instance attempt to deal with complaints when they occurred. Information on how to complain was contained in the patient leaflet, on the practice website, and was displayed in reception. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way.

We looked at a summary of complaints from the previous year, and could see that these had been responded to in a timely manner and a full investigation was undertaken. The patient was then contacted with a full explanation and where necessary an apology was made. Details of the Ombudsman had been made available if people were not happy with the outcome of the complaint investigation.

The practice summarised and discussed complaints at practice meetings, or where necessary on a one to one basis with staff members or as part of their appraisal. The practice was able to demonstrate learning and changes as a result of complaints, such as rewriting of practice information or retraining a member of staff. We saw minutes of meetings where shared learning and action points were discussed

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 and strategy to deliver high quality care and promote good outcomes for patients in an open and friendly environment. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these. The practice philosophy was described in the patient information leaflet and on the practice website.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews and listening to staff and patients.

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. A number of policies and procedures required review and the practice manager was in the process of doing this. Staff told us that they were aware of their roles and responsibilities within the team. Some members of staff had lead roles, these included palliative care and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication. The practice had not completed any audit cycles to review and monitor outcomes for patients in relation to treatments or medicines as part of monitoring and improving outcomes for patients.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working and in practice. The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance.

From a review of records including minutes from staff meetings, appraisals, complaints and significant event recording we saw that information was regularly reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments.

Leadership, openness and transparency

All staff we spoke with told us that GPs and the practice management team were approachable. They told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held weekly meetings and met more frequently when required, to discuss any issues or changes within the practice.

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

The practice sought feedback from patients on a regular basis through the Friends and Family Test. We reviewed the results from January and February 2015 and found that the overwhelming majority of patients who participated were extremely likely or very likely to recommend the practice to their friend and family.

The practice had an active Patient Participation Group (PPG). A PPG is made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. The PPG was formed of approximately 70 patients. The majority of patients participated to the group virtually by way of email and 15 members met regularly throughout the year. We spoke with one member of the PPG and they told us that the practice was open to and acted on, where possible, the suggestions made by the group. They told us of some examples of improvements that had been made as a result of suggestions made, including the widening of the front door and automatic opening doors to facilitate access to patients, particularly those with wheelchairs, motor scooters and prams. The appointment system had also been altered to allow more flexibility to patients. The PPG carried out patient surveys and the results from these were

Are services well-led?

Good

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

made available to patients as they were displayed in the patient waiting area. The results from the most recent survey, carried out in 2014 showed that patients were satisfied with the services they received at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff and those we spoke with said that they would feel confident in reporting any concerns.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned. Staff told us that the practice constantly strived to learn and improve patients' experiences and to deliver high quality patient care.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected time for learning and personal development.