

Dr James and Partners

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

This is the report from our inspection of Dr James and Partners Surgery. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 10 March 2015 at Dr James and Partners Surgery. We reviewed information we held about the services and spoke with patients, GPs, and staff.

Overall the practice is rated as good.

Our key findings were as follows:

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice had a holistic approach to patient care. The practice promoted health education to empower patients to live healthier lives.

- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The staff worked well together as a team.

We an area of outstanding practice including:

The practice offered support through shared care agreements for those patients who had addiction issues. The practice also ran joint clinics with a drug advisor to ensure patients received the correct medication, support and advice. Records showed that all patients who had a member of their family with an addiction issue had an alert placed on their record. This was to ensure the practice could offer appropriate support and safeguard against possible abuse or neglect.

However, there was also an area of practice where the provider needs to make improvements.

The provider should:

Summary of findings

Ensure there is a system in place whereby audits undertaken are centrally monitored to ensure identified actions are carried out and reviewed.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about patient safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their role.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand and access the local services available. We also saw that staff treated patients with kindness and respect.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example GPs attended GP forum meetings held by the CCG to ensure they were aware and involved with any issues and initiatives identified within their local area. Patients welcomed the emergency appointment system that operated for all appointments on Monday mornings. Information about how to complain was available and learning points from complaints were discussed in practice meetings.

Good



Are services well-led?

The practice is rated as good for being well-led. Staff were clear about the values of the practice being patient centred. The practice had a number of policies and procedures to govern activity and had identified the top 28 policies and procedures to ensure the staff read them and signed to say they understood them. Examples of the top 28 policies and procedures were safeguarding, confidentiality and infection control. There were systems in place to monitor and

Good



Summary of findings

improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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

The practice is rated as good for the care of 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, the avoidance of unplanned admissions scheme. The practice had a designated named GP for patients who were 75 years of age and over and care plans were in place for these patients. All patients with a plan had a direct line to the practice to speak to a GP should they need it.

The practice had a register of those patients who were housebound and the office manager coordinated with the nursing staff to ensure those patients were visited and offered vaccinations. Drop in clinics for vaccinations were advertised in the reception for all patients but at risk patients were sent specific letters to advise them of the need to have the vaccination.

The practice had access to a health improvement team who would visit patients in their home. There was information available to patients about services offered within the local community including those patients who may be experiencing social isolation.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. There were systems in place for call and recall of patients for annual reviews with a total of three letters being sent if patients failed to respond. Patients with long term conditions had alerts placed on their records to ensure they were offered a longer appointment with the GP.

The practice offered weekly clinics for patients taking warfarin and other anti-coagulation medicines to have their blood tested to ensure they were taking the right dosage. This service supported patients to be monitored and treated at the practice rather than having to attend the local hospital.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. The senior partner was the safeguarding lead for the practice. There were systems in place to identify and follow up children living in disadvantaged circumstances and also cases of domestic violence. Records showed the lead GP liaised and sought advice from other health and social care professionals when necessary.

Good



Summary of findings

The practice offered two post natal clinics per week where babies received their six week check carried out by a GP, babies received their immunisations and mothers were supported with breastfeeding. Health visitors attended both these clinics.

There was a system in place to follow up babies who had not been immunised and there was also an escalation procedure to GPs if this remained a concern.

Patients from the local settled traveller community were registered at the practice and were supported to access services including child immunisation programmes.

There was advice available in reception regarding access to community sexual health clinics held locally.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice currently does not offer extended hours we were told that this issue was to be reviewed following the employment of another GP.

Appointments with GPs and practice nurses were available from 9am until 6pm each day. Patients requiring minimal nursing support were offered appointments with the health care assistant from 8:30am.

All patients over 45 years of age were invited to attend a health check however the practice told us the uptake for this service was poor. There was health promotion information available in the waiting area and on the practice website.

Good



People whose circumstances may make them vulnerable

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register for those patients with a learning disability. Patients annual health checks were carried out by a GP and usually took place in their homes.

The practice had a register of carers that was shared with the carers champion at the CCG. The practice supported patients to access support and services based in the community including respite care.

The practice offered support through shared care agreements for those patients who had addiction issues. The practice also ran joint clinics with a drug advisor to ensure patients received the correct medication, support and advice. Records showed that all patients

Outstanding



Summary of findings

who had a member of their family with an addiction issue had an alert placed on their record. This was to ensure the practice could offer appropriate support and safeguard against possible abuse or neglect.

The practice had signed up to a CCG led service for patients who were under 18 and attended accident and emergency departments due to intoxication. This information was shared with the practice who invited the young person and their parents or carers to discuss the event.

The practice supported the local settled traveller community to access services including health checks and immunisation programmes.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and sign posted patients to the appropriate services. The practice participated in enhanced services for dementia and used screening tools to identify those patients at risk.

Those patients who experienced poor mental health received six monthly medication reviews.

Good



Summary of findings

What people who use the service say

As part of our inspection process, we asked patients to complete comment cards prior to our inspection.

We received 34 comment cards and spoke with two members of the Patient Participation Group (PPG). All comments received indicated that patients found the reception staff helpful, caring and polite and the majority described their care as excellent.

For the practice, our findings were in line with results received from the National GP Patient Survey. For example, the latest national GP patient survey results

showed that in January 2015, 78% of patients described their overall experience of this surgery as good (from 114 responses). Ninety five per cent found the last appointment they got was convenient this was significantly higher than the national average.

Results from the National GP Patient Survey also showed that 57% patients find it easy to get through to this surgery by phone this is lower than the CCG average and 95% had confidence and trust in the last nurse they saw or spoke to, this is higher than the CCG average.

Areas for improvement

Action the service **SHOULD** take to improve

Ensure there is a system in place whereby audits undertaken are centrally monitored to ensure identified actions are carried out and reviewed.

Outstanding practice

The practice offered support through shared care agreements for those patients who had addiction issues. The practice also ran joint clinics with a drug advisor to ensure patients received the correct medication, support and advice. Records showed that all patients who had a

member of their family with an addiction issue had an alert placed on their record. This was to ensure the practice could offer appropriate support and safeguard against possible abuse or neglect.

Dr James and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor and practice manager specialist advisor.

Background to Dr James and Partners

Dr James and Partners (Market Street Surgery) is located in Newton le Willows, St Helens, which is a deprived area of the country. The practice is located in a large semi-detached property in the centre of the town. There were approximately 8000 patients on the practice list.

The practice has four partner GPs and a salaried GP in addition there are nurses, a healthcare assistant, a practice manager, office manager and reception and administration staff. The practice is open 8.30am to 6pm Monday to Friday. The practice has open access clinics at various times throughout the week to accommodate same day appointments. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service that is provided by local GPs. The number of this service is clearly displayed in the reception area and on the practice website. The practice has a GMS contract and also offers enhanced services for example; various immunisation and learning disabilities health check schemes.

The practice was a designated teaching practice for the training and education of student doctors they had robust systems in place to support student doctors including weekly tutorials.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Detailed findings

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 10 March 2015.

We spoke with a range of staff including three GPs, the practice manager, two practice nurses a healthcare assistant, reception staff and administration staff, on the day. We sought views from representatives of the patient participation group and looked at comment cards and reviewed survey information. We also spoke with patients visiting the practice on the day of the inspection.

Are services safe?

Our findings

Safe track record

There was a system in place for reporting and recording significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process. Information we received from NHS England and the CCG did not identify any concerns with this practice.

Learning and improvement from safety incidents

Staff were encouraged to complete significant event reporting forms via the practice's computer system. The practice held meetings at which significant events were discussed in order to cascade any learning points. We viewed documentation which included details of the events, details of the investigations, learning outcomes including what went well and what could be improved. For example a time delay had occurred before a patient's abnormal blood result had been checked by a GP. Following the investigation learning outcomes had been identified and changes to how abnormal test results were managed had been put into place.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and undertook on-going audits to ensure best practice.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition, there were flow charts for guidance and contact numbers displayed within the reception area and treatment areas. The senior partner was the lead for safeguarding.

All staff had received safeguarding children training at a level suitable to their role, for example all clinicians had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection processes. The lead GP liaised with health and social care professionals when necessary to discuss children and adults who may be at risk.

A chaperone policy was available on the practice's computer system. The practice nurses and healthcare assistant acted as chaperones. However, the staff had received chaperone training and could act as chaperones if required to do so. At the time of the inspection the practice had applied for disclosure and barring (DBS) checks for all reception and administration staff. Until these checks had been carried out only staff with DBS checks were carrying out chaperone duties.

Medicines management

The practice worked with pharmacy support from the local CCG. Regular medication audits were carried out with the support of the pharmacy team to ensure the practice was prescribing in line with best practice guidelines.

The practice had one fridge for the storage of vaccines. One of the practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the treatment room. One of the practice nurses had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

Prescriptions were held securely and there were systems in place to monitor the use of prescriptions.

Cleanliness and infection control

All areas within the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was

Are services safe?

available. Hand gels for patients were available throughout the building including the waiting area. Clinical waste disposal contracts were in place and spillage kits were available.

One of the practice nurses was the designated clinical lead for infection control. There was an infection control policy in place. The practice nurses received regular infection control training and updates. There were infection control audit systems in place including cleaning schedules and on-going monitoring of the cleaning contract with an external company.

The practice manager was the lead for health and safety and was responsible for the compliance with fire, Legionella and other health and safety regulations for the premises.

Equipment

All electrical equipment was checked to ensure the equipment was safe to use.

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

There was medical equipment available to deal with emergencies in the practice including a defibrillator, oxygen and an emergency treatment bag. The defibrillator was self-calibrating and battery operated with an audible and visual alarm to alert staff to battery power running down. The emergency bag was well stocked and had a contents list which was checked against the contents on the day. Audits were carried out by the healthcare assistant to ensure all emergency equipment and medicines were in date.

Staffing and recruitment

Staff told us there were enough staff to meet the needs of patients and they covered each other in the event of unplanned absences.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All staff working at the practice either had a DBS check in place or one had been applied for to ensure they were suitable to carry out their role. Particularly with regard to reception and administration staff carrying out chaperone duties.

Monitoring safety and responding to risk

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety. There was a health and safety policy available for all staff. The practice had recently carried out a fire drill. We discussed with the practice manager the need to review the environmental risk assessment annually or sooner if a risk was identified the practice manager agreed to do this.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen. There was a formal medical emergency protocol in place and when we discussed medical emergencies with staff, they were aware of what to do.

The practice had a disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do if faced with a major incident.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the practice nurses carried out a full health check which included gathering information about the patient's individual lifestyle as well as their medical conditions. Patients were booked for extended appointments to discuss their needs and to also be introduced to what services were available in order for patients to make best use of the practice. The practice nurses referred the patient to the GP when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. For example clinical governance meetings and GP leads for areas such as palliative care, minor surgery and safeguarding.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, patients with a learning disability and those on the palliative care register.

There were a number of effective assessment systems in place. For example patients on the palliative care register who required out of hours treatment or support were seen by a GP from the practice. This enabled the practice to provide effective and continuous care to palliative care patients.

The practice took part in the avoiding unplanned admissions scheme. The clinicians discussed patient's needs at meetings and ensured care plans were in place and regularly reviewed.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice.

All GPs and nursing staff were involved in clinical audits. Examples of audits included antibiotic prescribing and safeguarding systems. Some audits such as the prescribing of Tamoxifen medication and its interaction with other

medicines resulted in a greater prescribing awareness for all GPs. There was no clear system in place to enable the practice to monitor action plans put in place following an audit having taken place.

The practice also met with the local (CCG) to discuss performance.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. The induction programme provided staff with a clear overview of the practice and provided opportunities for newly appointed members of staff to shadow various team members.

Staff received training that included: - safeguarding vulnerable children, basic life support and information governance awareness. There was a training schedule in place to demonstrate what training staff had previously received or were due to receive. The practice was closed for half a day a month to accommodate training that was organised by the local CCG.

The practice nurses attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The nurses were given protected learning time and supported to attend meetings and events.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (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). There were annual appraisal systems in place for all other members of staff.

Working with colleagues and other services

Incoming referral letters requiring action were immediately passed to the GPs prior to scanning the information onto the patient's notes.

Patients were referred to hospital using the 'Patient Choose and Book' system and the practice followed the two week rule for urgent referrals such as cancer. The practice had monitoring systems in place to check on the progress of any referral.

Are services effective?

(for example, treatment is effective)

The practice liaised with other healthcare professionals such as the Community Diabetic Specialist, the Community Matron, the palliative care team and the Community Mental Health and wellbeing Nurse.

Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. Individual clinical cases were analysed at a clinical team meeting as necessary. For example, the practice in conjunction with community nurses and matrons held regular Gold Standard Framework (GSF) meetings for patients who were receiving palliative care.

The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding unwell patients who may require assistance over a weekend.

The practice operated a system of alerts on patients' records to ensure staff were aware of any issues, for example, alerts were in place if a patient was a carer.

Consent to care and treatment

The practice had a Mental Capacity Act policy in place to help GPs with determining mental capacity of patients. We spoke with the GPs about their understanding of the Mental Capacity Act 2005 and Gillick guidelines they demonstrated a good understanding of their roles and responsibilities.

The lead GP was aware of Gillick guidelines for children. Gillick competence is used in medical law 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.

The practice carried out joint injections and we found appropriate information and consent forms for patients were in place. For example records showed the GP discussed procedures with patients including risks and benefits and alternative treatments.

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia. The practice made use of a TV screen to alert patients about health issues and the need for attending regular screening and immunisations. The practice website offered a health promotion and healthy lifestyle information to support patients to manage their health and wellbeing.

The practice staff sign posted patients to additional services such as lifestyle management and smoking cessation clinics.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous caring and very helpful to patients both attending at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the national GP patient survey showed that approximately 86% of patients said the last GP they saw or spoke to was good at treating them with care and concern this was in line with the national average. The patient survey also showed that approximately 33% of patients stated that they always or almost always see or speak to the GP they prefer this was in line with the national average.

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

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed approximately 87% said the last GP they saw or spoke to

was good or very good at involving them about their care which was higher than the national averages. The survey also showed that approximately 88% said the last nurse they saw or spoke to was good at involving them in decisions about their care which was higher than the national average.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

Patient/carer support to cope emotionally with care and treatment

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

There was supporting information to help patients who were carers on a designated notice board in the waiting room. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support. The practice did not refer patients on their palliative care register to their out of hours GP service. For this group of patients and their carers they were provided with a separate telephone number to enable them to contact the practice and to be seen by a GP from the practice. This service supported patients and their carers to receive continuity of care and support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available on the practice's website. The PPG met quarterly and patient surveys were sent out annually. We spoke with two members of the group who told us the practice had been responsive to any of their concerns. For example, the practice in response to patient's comments had reviewed and put in place a new system to manage non-attendance at appointments.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements. For example the practice had signed up to a CCG led service for patients who were under 18 and attended accident and emergency departments due to intoxication. This information was shared with the practice who invited the young person and their parents or carers to discuss the event.

Tackling inequity and promoting equality

The practice had a small proportion of minority groups for whom English was not their first language. The practice recorded patient's language and ethnicity at registration. The surgery had access to translation services. The building had appropriate access for disabled people.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

Access to the service

The practice was open between 8.30am to 6pm Monday to Friday. The practice operated an open access clinic on

Monday mornings for emergency appointments; a further 50% of the afternoon appointments were allocated for emergency appointments. From Tuesday to Friday one GP offered same day appointments for all allocated appointments in the morning and for 50% of the allocated appointments in the afternoon. The practice offered patients telephone consultations when appropriate as an alternative to an appointment. Members of the PPG told us that this access system worked well and the practice made every effort to provide 'seamless care'.

The service offered home visits to those patients who were housebound or too ill to attend the practice. Out of hours care was also provided by the practice to those patients on their palliative care register.

The patient survey indicated that 64% of patients were satisfied with the surgery's opening hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

Information about how to make a complaint was available on the practice's website and on the television screen in the waiting room. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a complaints log book and there had been very few formal complaints received over the past 12 months. Learning points from complaints were discussed at staff meetings. We discussed with the practice manager the need to record all issues raised by patients even if they were resolved quickly. The practice manager agreed to do this.

Are services well-led?

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

Our findings

Vision and strategy

Staff we spoke with were aware of the culture and values of the practice and told us patients were at the centre of everything they did. They felt that patients should be involved in all decisions about their care and that patient safety was also paramount. Comments we received were very complimentary of the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

Governance arrangements

The practice had a clinical governance policy in place. The governance policy covered: patient involvement, clinical audit, staffing, and education and risk assessments.

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The practice had identified the 'top 28' policies and procedures that they as a team felt supported them to provide a safe and quality service to patients. The policies included a 'Health and Safety' policy, 'consent to treatment policy' and 'Infection Control' policy. All the policies reflected current best practice and legal requirements.

Leadership, openness and transparency

Staff had specific lead roles within the practice for example safeguarding and infection control. There was a practice manager who oversaw the administrative support staff.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest. For example, the practice closed for lunch and this time was used for the whole staff team to spend time together and discuss any issues that may have arisen.

Practice seeks and acts on feedback from its patients, the public and staff

Results of surveys and complaints were discussed at staff meetings. There was a patient participation group (PPG) in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with two members of the PPG who told us the PPG felt that the practice was responsive to any issues raised by the group. They told us that the practice was very patient centred and had involved them in any proposed changes to the service.

The practice reception staff and information available on the practice website encouraged patients to complete the new Friends and Family Test as a method of gaining patients feedback. We also saw evidence that the practice listened to staff feedback and acted accordingly.

Management lead through learning and improvement

The practice worked well together as a team and held meetings for team learning and to share information. There were regular formal clinical meetings with set agendas covering all aspects of patient safety. The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and ensured the whole team was involved in driving forward improvements. They recognised future challenges and areas for improvement.

The practice was a designated teaching practice for the training and education of student doctors they had robust systems in place to support student doctors including weekly tutorials. The lead GP told us being part of the education and training of future doctors enabled them as individual clinicians and as a practice to continue to develop and improve the service they provided to patients.