Gloucester City Health Centre - WG

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

Gloucester City Health Centre is a city centre practice providing primary care services to patients resident in Gloucester. The practice has a patient population of approximately 8,000.

We undertook a comprehensive announced inspection on 7 January 2015. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector, a nurse specialist advisor and a GP specialist advisor.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Gloucester Clinical Commissioning Group (CCG), NHS England and Healthwatch Gloucester.

The overall rating for Gloucester City Health Centre is good. Our key findings were as follows:

- Patients were able to get an appointment when they needed it.
- Staff were caring and treated patients with kindness and respect.
- Staff explained and involved patients in treatment decisions.
- Patients were cared for in an environment which was clean and reflected good infection control practices.
- Patients were protected from the risks of unsafe medicine management procedures.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- The practice had systems to identify, monitor and evaluate risks to patients.
- Patients were treated by suitably qualified staff.
- GPs and nursing staff followed national guidance in the care and treatment provided.

We saw several areas of outstanding practice including:

- A GP triage system for patients who require urgent care which offered a medical consultation to all patients who contacted the practice and enabled patients to receive the most appropriate treatment.

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- We were told that special arrangements had been put into place by the practice for dealing with the expected death of a member of the local Muslim community which allowed for an immediate funeral.
- Patients who had difficulty attending the practice were routinely visited by the practice nurses who undertook monitoring tests such as the International Normalised Ratio test which is a standardised method of reporting the effects of an oral anticoagulant on blood clotting.

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. We found the practice had systems, processes and practices to keep people safe in place and these were communicated to staff. Staff understood their responsibilities to raise concerns and incidents. Safety was monitored using information from a range of sources and we found improvements had been made when things went wrong. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The practice was responsive to changing risks for patients who used services, including deteriorating health and wellbeing or medical emergencies. The practice had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice demonstrated patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits to evaluate prescribed treatment. We found staff had the skills, knowledge and experience to deliver effective care and treatment. Patient's consent to care and treatment was always sought in line with legislation and guidance, such as written consent for minor surgery.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients' feedback about the practice indicated they were treated with kindness, dignity, respect and compassion while they received care and treatment. The practice took into account patients' cultural, social and religious needs for example language interpreters were available if needed. We found the practice routinely identified patient's with caring responsibilities and supported them in that role. Patients who used the practice fed back that they were routinely involved in planning and making decisions about their care and treatment.

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Are services responsive to people's needs?

Good

The practice is rated as good for being responsive to patients needs. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was 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. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. 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

Good

The practice is rated as good for the care of older patients. The practice provided a named, accountable GP for all patients aged 75 and over. The practice worked collaboratively with other agencies to implement a range of monitoring and preventative measures such as telehealth systems which enabled individuals to take more control over their own health, by allowing them to monitoring vital signs, such as blood pressure, and transmitting the information to a monitoring center.Monthly multidisciplinary meetings were held with community teams to discuss the most vulnerable patients. The practice maintained a register of vulnerable patients. It was updated as appropriate and the care needs of patients were regularly reviewed. For patients requiring end of life care and support, a palliative care meeting was held every three months with the lead GP. The practice also supported older patients living in residential or nursing homes locally.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. The practice provided specialist nurse support for conditions such as asthma, diabetes and heart disease. Patients' conditions were monitored and reviewed with planned appointments sent directly to them. We found patients were assessed and signposted to the most appropriate support. The senior nurse had specialist knowledge and awareness of diabetes, and had developed and promoted insulin initiation, without the need for referral to the hospital. All of the practices diabetic patients attended a yearly review. The practice promoted self-care and offered patients with long term conditions an assessment and education to use tele health. Vulnerable patients had a care plan which could include emergency medicines such as antibiotics or steroid therapy. The care plan was made available to the Out of Hours service.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young patients who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us and we saw evidence that children and young patients were treated in an age appropriate way and recognised as individuals. Appointments

were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. The practice liaised with a range of other agencies regarding patients for example, the sexual health clinic. Young adults were able to access confidential appointments with a GP.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). GP and nurse appointments were arranged to accommodate work commitments when required by patients. The practice had extended hours, and opened on Saturday mornings for planned appointments. The practice also provided telephone consultations and an online prescription service to patients. NHS health checks were offered to all patients aged 40-74. We found the practice participated in health screening programmes such as the national cervical cancer screening programme.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice had a system of identifying those patients in vulnerable circumstances who may experience difficulty accessing services such as those with learning disabilities or those patients whose first language was not English. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients living with dementia. The data provided by the practice showed 98.25% of patients experiencing poor mental health had received their annual health check. The practice

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sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for patients with mental health needs and dementia. Patients at the practice had access to psychological therapies and self-help groups through psychology services which ranged from self-help therapies, to psycho-educational courses and one-to-one support.

Summary of findings

What people who use the service say

During the inspection we spoke with four patients who told us they were very satisfied with the service received from the practice. Patients told us they felt the practice was excellent and helpful and told us they would recommend the practice to other patients.

The practice completed an annual patient satisfaction survey for 2013. This showed

- 92% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care.
- 91% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care.
- 99% of respondents said the last appointment they got was convenient.

All of these results exceeded the average score for the Gloucestershire Clinical Commissioining Group.The survey results were corroborated by the comments made by the patients we spoke with during our visit.

We also had 50 patients complete our comment cards. These showed a high level of satisfaction with all areas of the practice and included positive comments about staff being highly skilled, respectful and considerate and about GPs listening to patients and providing clear explanations.

Patients told us that if they did not see their regular GP they were happy to see another at the practice. Patients told us this was because they had found information was shared between GPs, detailed information was recorded in their records, and GPs had a good awareness of their needs.

Patients told us staff listened to them and supported them well particularly if they were carers and were looking after relatives who were unwell. Patients told us they valued the emotional support they received from staff. They said they had access to counselling through the practice which they found extremely helpful.

The practice had a patient forum that consisted of approximately 15 members who represented the demographic of the practice population. The practice arranged regular meetings with these members to discuss any improvements that could be made to the practice. We spoke with the chairperson of the group who told us about the regular meetings at the practice. We were told the practice had listened to the group and took their views into account when making decisions about the practice. For example, the group had suggested a newsletter to be made available in the practice and on the website and this had been actioned. We were also told how the practice supported the group to function by providing the administrative support for minute taking.

Outstanding practice

- A GP triage system for patients who required urgent care which offered a medical consultation to all patients who contacted the practice and enabled patients to receive the most appropriate treatment. The practice policy was that all patients who needed an appointment were seen on the day. Triage improved the accessibility of appointments for patients as unnecessary visits were eliminated. The practice also used the results of this system to plan GP and nurse availability.
- Patients who had difficulty attending the practice were routinely visited by the practice nurses who undertook monitoring tests such as the International Normalised Ratio test which is a standardised method of reporting the effects of an oral anticoagulant on blood clotting. This allowed for earlier interventions when needed, for example, a change in dosage of medicine.
- We were told that special arrangements had been put into place by the practice for dealing with an expected death of a member of the local Muslim community which allowed for an immediate funeral.

Gloucester City Health Centre - WG

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 GP and practice nurse special advisor.

Background to Gloucester City Health Centre - WG

Gloucester City Health Centre – WG is situated in the inner city area of Gloucester. It has approximately 8000 patients registered with a range of cultures and ethnicity with a high number of patients from black and minority ethnic communities (approx. 21.8 % of registered patients). There is a telephone interpretation service available onsite to assist with any translation issues.

The practice is in an area of high deprivation with the Index of Multiple Deprivation at 32.29 which is over twice the Clinical Commissioning Group average of 15.05. The practice has a low number of patients over 75 years compared to the CCG average. The patient gender distribution was male 50.68 % and female 49.32 %.

The practice operates from one location:

Gloucester City Health Centre

The Park

Gloucester GL1 1XR

The practice is made up of six GP partners and two salaried GP's of both genders working alongside three qualified nurses and one health care assistant (all female).

The practice was previously inspected by the Care Quality Commission (CQC) on 10 December 2013 and was found to be compliant in the five outcome areas that were inspected.

The practice has a general medical services contract with some additional enhanced services such as extended hours for pre booked appointments and unplanned admission avoidance. The health centre is open on Monday, Tuesday, Thursday and Friday between 8am-12:30pm and 1:30pm–6pm. On Wednesday from 7:30am-12:30pm and 1:30pm-6pm, and

Saturday from 8am-11pm for pre-booked appointments only. The practice nurse operates an early morning clinic on a Wednesday between 7.30am and 8am.

The practice does not provide out of hours services to its patients, this is provided by South Western Ambulance Service NHS Foundation Trust in partnership with the Gloucestershire GP provider company Limited. Contact information for this service is available in the practice and on the website.

The CQC intelligent monitoring placed the practice in band four. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands,

with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we received from other organisations such as the local Healthwatch, the Gloucester Clinical Commissioning Group (CCG), and the local NHS England team.

We carried out an announced visit on 7 January 2014 between 9am - 5pm.

During our visit we spoke with a range of staff, including GPs, nurses, receptionist, practice manager and administrative staff.

We also spoke with patients who used the service. We observed how patients were being cared for and reviewed the patient information database to see how information was used and stored by the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older patients (over 75s)
- Patients with long term conditions
- Mothers, children and young patients
- Working age population and those recently retired
- Patients in vulnerable circumstances who may have poor access to primary care
- Patients experiencing poor mental health.

The patient population group age profile information provided by NHS England was:

- 0-4 years 6.74 %
- 5-14 years 11.59 %
- 15-44 years 45.06 %
- 45-64 years 23.69 %
- 65-74 years 6.71 %
- 75-84 years 4.63 %
- 85 years + 1.58 %

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. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We reviewed safety records and incident reports and minutes of meetings which showed the practice had managed these consistently over time. The practice used an electronic patient record system. Any significant medical concerns or additional support needs were added as alerts to patients' records. These appeared when a record was opened and alerted the GP or nurse to significant issues relating to that patient and their care. For example, if a patient had communication difficulties or had missed an appointment. Staff also understood that patients may be supported by a carer or a relative to act as an advocate for them, and this information was recorded on the patient record. For example the practice had reviewed their child protection coding processes to ensure correct information was recorded so that practitioners were alerted if patients had a protection plan.

The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Gloucester Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits, significant events analysis and complaints.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found there were four reportable significant events that had occurred in the last 12 months. Staff told us profoma for incidents were sent to the practice manager, who explained how incidents were managed and monitored. We were told significant events were discussed as they arose in order to identify whether urgent action would be required. We tracked two incidents and saw records were comprehensively completed. The practice had a system to put in place corrective action following incidents and to share learning with all staff. A slot for reviewing significant events was on the practice meeting agenda and a dedicated meeting took place every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff, including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings.

National patient safety alerts were disseminated by the practice manager to practice staff. The practice manager told us alerts were discussed at the practice business meeting. Staff confirmed information was shared and any remedial action agreed and implemented as a team. The staff also had regular meetings where they could review themes and change processes if needed. There was an annual overview of significant events which was collated by the practice manager. This enabled the practice to review any themes and make changes if needed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable patients. Vulnerable patients included looked after children and children on the 'at risk' register. Vulnerable patients also included those at risk of experiencing domestic violence, patients with a learning disability, patients with a diagnosed mental health condition such as dementia and patients living in care homes. GPs told us they applied the same safeguarding principles to patients who lived in care homes settings as they were perceived to have a greater degree of vulnerability.

The practice's electronic records system had an alert mechanism so staff were made aware there were other important issues to consider when these patients attended appointments. For example, if children had persistently failed to attend appointment for childhood immunisation. The practice also had a system in place to monitor patient attendances at accident and emergency centres and use of Out of Hours services and urgent care centres.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children. The GPs were trained to level three standard in child protection to enable them to fulfil this role. The practice ensured all staff had attended safeguarding training commensurate with their

role. The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as the police and social services. GPs met regularly with health visitors to enable regular discussion and information sharing about looked after, at risk children and any vulnerable families. The practice manager confirmed these arrangements worked well and the health visitors could access the staff at the health centre to share information. Children for whom concerns had been identified had either an individual care plan or a shared plan with the health visitors. The GPs confirmed they had been invited to attend case conferences but could not always attend. However; they completed any documentation for the meetings and were provided with minutes and actions. They confirmed they were sometimes required to attended serious case reviews for patients registered with the practice.

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We observed contact details were easily accessible around the practice. The GPs and nurses were aware of the Gillick competence requirements and ensured children were accompanied by an adult if they needed to see a GP or nurse. A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by nursing staff.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. This system allowed other healthcare professionals to add clinical records and test results.

Medicines Management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under patient specific direction from a registered prescriber which had been reviewed and approved in line with national guidance and legal requirements. We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines. The nursing staff received regular clinical supervision and support in their role from the GPs.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us this helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines, for example prescribing controlled drugs. GPs and nurses were responsible for monitoring the effectiveness of diagnostic testing. An alert was placed on the computer system to ensure relevant tests had taken place and it was safe for the patient to continue taking prescribed medicine.

The practice set a target of getting medicines to patients within 48 hours. This was overseen by one of the GPs so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the administrative staff sent their discharge summary to the appropriate GP for checking and authorisation of any changes.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Hand hygiene techniques signage was displayed in staff and patient toilets. 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 clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control that provided advice on the practice infection control policy and carried out staff training. All staff received induction training about infection control specific to their role and there after regular updates. We saw evidence the lead nurse had carried out an audit and that any improvements identified for action were completed. Practice meeting minutes showed the findings of the audits were discussed if action was needed; for example, the flooring in the phlebotomy room was not washable and had been identified for replacement. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. We found personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury.

The practice relied on the landlord for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw confirmation this was completed for the practice.

Equipment

The practice was suitably designed and adequately equipped. The fabric and fixtures and fittings of the building were maintained on behalf of the practice by the landlord. We saw equipment such as computer screens was supplied maintained by an external NHS contractor, however software programmes were the responsibility of the practice. This meant the practice retained responsibility for the safety and confidentiality of patient and staff information. The computer based record systems were password protected and backed up to an external server which protected the surgery against data loss. Equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency) centrally located and all staff were trained in its use.

All portable electrical equipment was routinely portable appliance tested (PAT) and displayed current stickers indicating testing. Single use examination equipment was stored hygienically and was disposed of after use. Other equipment was wiped down and cleaned after use. When equipment became faulty or required replacement, it was referred to the practice manager who arranged for its replacement.

Staffing & Recruitment

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

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice was located in an older purpose built environment part of which it leased, the other accommodation was occupied by the landlord who provided other healthcare services. The maintenance of the actual building and external grounds was managed by the landlord. The health and safety of the building in respect of patient and staff safety, was managed by the practice. We were shown the systems, processes and policies in place to manage and monitor risks to patients,

staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We were told that risks were discussed at GP partners' meetings and within team meetings. For example, the practice had been in negotiation to move to new, larger premises which would allow the services to be further developed. The current building used by the practice had limited space especially in the consultation and treatment rooms, and needed a number of environmental improvements. We saw a plan for the extension and refurbishment of the practice which showed the management team had been proactive in recognising and addressing the potential risks to the service.

Staff told us how they recognised and responded to changing risks to patients and staff. Staff told us they had been trained in what to do in an urgent or emergency situation and about the practice's procedures in such circumstances.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff had recently completed basic life support training and were able to tell us the locations of all emergency medical equipment and how it should be used. Emergency equipment was available including access to oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children. We were told there was always a first aider and first aid equipment available on site when the practice was open.

Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. The practice held a list of the medicines' expiry dates and had a procedure for replacing medicines at that time. Staff knew where emergency medicines were stored and how to use them, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable, for example, through poor mental health. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

On the day appointments were available each day both within the practice and for home visits. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had not ever been refused access to a GP.

The practice had an alarm system within the computerised patient record system to summon help. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The document also contained relevant contact details for staff to refer to. For example, contact details of the computer system supplier in the event of failure.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety risk assessment. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. Risks associated with service and staff were included on the practice risk log. We saw an example of this as the practice had identified that when they were open on a Saturday morning a minimum of two staff would always be in the building to respond to emergencies.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment.

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice manager explained how new guidelines were disseminated, and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of diabetes.

There were processes for making referrals to specialist or investigative services. The practice ensured that all test results received into the practice were reviewed on the day they were received. If the GP who ordered the test was not working then the results were reviewed by the duty doctor so any urgent actions could be taken. The GPs and practice manager confirmed to us urgent referrals were completed on the same day and others within a 48 hour window. We saw no evidence of discrimination when making care and treatment decisions and the practice operated a daily peer review of all referrals. Interviews with GPs informed us the culture in the practice was that patients were referred based on need and age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for patients.

We found the GP in the practice who undertook minor surgical procedures had completed additional training to be able to do so and undertook these procedures according to National Institute for Health and Care Excellence (NICE) guidance. We saw each procedure had been recorded and samples from patients were sent for testing. All the results from the tests were recorded and evaluated against the procedure that had been performed. This clinical audit provided assurance that appropriate treatment had been given and that any further follow up treatment was actioned.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to monitor and report performance. The practice also participated in local benchmarking run by the Clinical Commissioning Group. This was a process of evaluating performance data from the practice and comparing it to similar practices in the area. For example, this benchmarking data showed the practice achievement for Diabetes Retinal Screening in 2012-13 was 91% which was above the national average of 89.68%.

The practice showed us several clinical audits that had been undertaken in the last year. We were given examples of how additional monitoring was put in place for patients taking a specific medicines. We spoke with the pharmacist who supported the practice and asked about the prescribing of hypnotic medicines, a type of medicines is to induce sleep and used in the treatment of insomnia (sleeplessness). The practice is an outlier in this area (a measure which highlights when a practice performance is outside of the accepted range). The pharmacist had investigated this issue and audited all the patients at the practice who took this medicine. This information was shared with the GPs who reviewed the patient's medicines. This had been successful for some patients who were prescribed alternative medicine. We also heard from the pharmacist how they audited patients who were prescribed high risk medicines and worked with the staff at the practice to ensure patients were monitored so that medicines were used safely. The GPs were also able to share information about the clinical audits they had conducted which impacted directly on patient care. We read the information collated to assess the effectiveness of the GP triage system which found that the system had given improved access to GPs for patients.

Good

Are services effective?

(for example, treatment is effective)

The patients with long-term conditions we spoke with told us their conditions were well managed and routinely monitored and patients told us their health conditions had stabilised. We saw monitoring and management programmes for patients with long-term health conditions such as diabetes, anaemia and coronary heart disease. Patients with these conditions had regular blood tests to monitor whether the level of medicines they were taking remained safe and effective. The practice used the information it collected for the Quality and Outcomes Framework (QOF) and its performance against national screening programmes to monitor outcomes for patients. For example, the practice exceeded the national achievements for QOF in the management of diabetes..

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with a number having additional diplomas in specialist areas of medicine. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (This is the assurance on which NHS England bases a recommendation every 5 years to the General Medical Council (GMC) that the GP should continue to hold a Licence to Practice. When this has been confirmed by GMC the GP can continue to practise and remain on the NHS England performers list).

All staff had an annual appraisal that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, one healthcare assistant told us they had been supported by the practice to complete training to extend their role.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, the administration of vaccines and cervical cytology screening. Those with extended roles saw patients with long-term conditions such as asthma, diabetes and coronary heart disease and were able to demonstrate they had appropriate training to fulfil these roles.

We reviewed how the practice planned the staff team to safely meet patient needs and found that the practice had identified peak times for patient contact and used this for staff planning. Staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. This ensured there was sufficient cover for staff annual leave. All staff were flexible and able to cover shortfalls to ensure patient care. The practice had a detailed induction programme for new staff which included orientation within the practice such as learning the procedures specific to their role, reception skills and also basic training courses. We saw evidence of this in the staff files.

GP illness and planned absence was managed and the partners covered any shortfalls. We found the practice were proactive with recruitment for a GP for example, to cover maternity leave. The practice had staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. There was evidence ongoing checks had been made in relation to professional registration and continuing professional development.

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role through a range of learning programmes. The patients we spoke with told us they felt staff were appropriately skilled and knowledgeable.

Working with colleagues and other services.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice had well established working arrangements with a range of other services such as the community nursing team, the local authority, local nursing and residential services, the hospital consultants and a range of local voluntary groups. The practice held multidisciplinary

team meetings monthly to discuss patients with complex needs, for example, those with end of life care needs or children on the 'at risk' register. These meetings were attended by district nurses, social workers, and palliative care nurses. Decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The patients we spoke with told us they had been referred quickly to specialists and consultants for further tests or treatment. They also told us how they were referred to voluntary groups for support at times, as well as community nursing services. Patients told us they had received test results promptly and had discussed with GPs and nurses their options for ongoing treatment and support.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, the practice operated a shared care system with Out of Hours services for vulnerable patients, those who may be at the end their life or for those acutely unwell who may need out of hours support. They ensured care plans were updated and accessible. Staff felt this process promoted continuity of care for patients and reduced hospital admissions. Electronic systems were also in place for making referrals.

The practice had systems in place to provide staff with the information they needed. The records system used by the practice allowed for blood results and information from other healthcare providers to be recorded. For example, discharge letters were scanned onto the system and were available to GPs and nurses. The system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained in using the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Patients were consulted about and involved in making decisions relating to their care and treatment. Staff were aware of the Gillick competencies and when to use them. These refer to decisions about whether a child was mature enough to make decisions about their own medical treatment. We were told that where a patient was deemed to be 'Gillick competent', patient records would be updated to reflect this.

We found that staff were aware of the Mental Capacity Act (2005) and their duties in fulfilling it. All the GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The staff had undertaken e learning in this area. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in devising. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown records that confirmed the consent process for minor surgery had been followed. The practice had written consent forms for minor surgery and for the insertion of intrauterine devices.

Health Promotion & Prevention.

The practice had met with the Public Health team from the local authority and the Clinical Commissioning Group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity such as smoking cessation and leading more active lives.

The practice offered a range of health promotion and prevention support to all patients. Health promotion and prevention advice was provided as part of routine GP and nursing appointments. The advice was supported by a range of information available within the practice and on the practice's website. Information was available about health and lifestyle issues such as keeping healthy, living a healthy lifestyle, preventing illness, and preventing any existing illness from becoming worse. Leaflets included

Good

Are services effective?

(for example, treatment is effective)

information about diet, obesity, smoking, exercise, alcohol, preventing heart disease, cervical screening, and breast screening. The practice also offered health promotion advice and counselling for a variety of issues such as substance and alcohol misuse and contraception. Information advice about treatment options was available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support via the practice website.

It was practice policy to offer all new patients registering with the practice a health check. The GP was informed of all health concerns detected and these were followed-up. Routine health checks were available for diabetes, hypertension and prostate problems and routine screening was available for chlamydia, dementia and cervical cancers. We asked about the practice's performance for cervical smear uptake being 68%, which was worse than the national average. We were told that the practice offered access to these tests but take up by female patients from certain ethnic groups was low despite direct contact from the practice.

The practice identified patients who needed additional support, for example, the practice kept a register of vulnerable patients including those with learning disabilities, dementia, mental health conditions and

patients in nursing homes. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 90% attended for a health check in the last 12 months. There was also a regular meeting between the practice and the learning disability service to discuss any issues or initiatives. The practice had increased their dementia diagnosis over the last year through cognition testing.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw the up to date information on their performance for all immunisations which was above average for the CCG at 95% for 2013, and there was a clear policy for following up non-attenders by the named practice nurse.

The practice kept a register of patients who were identified as being at high risk of hospital admission, had a diagnosis of dementia, or who were nearing the end of their life. Up to date care plans were completed and shared with other providers such as the Out of Hours service. Multidisciplinary case management meetings took place at regular intervals and care plans were updated every three months. All patients over the age of 75 had a named GP and for those who lived in residential or nursing home there were two named GPs who made regular visits.

All patients with long term conditions had a named accountable GP. Care was tailored to individual needs and circumstances with regular reviews if necessary prompted from repeat prescribing system and formal recalls. Disease management clinics were run by multi-skilled nurses and included, diabetes, asthma and chronic obstructive pulmonary disease (COPD). The practice operated a formal appointment recall system for patients in these groups. Home diabetic checks and flu vaccinations were provided for housebound patients. Flexible access to services including same day appointments, same day telephone consultations and flexible disease management clinics were also available.

Young patients were offered appointments with a female or male GP as requested. They could access contraception advice, sexual health advice and contraception medicines including intrauterine contraceptive devices, implants and emergency contraception. Same day appointments were provided for discussions about emergency contraception.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction undertaken by the practice's patient participation group (PPG) in 2013. 380 patients were involved in the survey which was a sample size of approximately 5% of the registered patients. The responses from this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, in response to the question 'Would you recommend your surgery?' 93% of responses were positive. The practice was above average in the national patient survey where 91% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments which was above the local Clinical Commissioning Group average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 50 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. The less positive comments from seven patients had a common theme of poor access through the telephone system. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains and screening were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We observed consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The layout of the reception area and the seating in the waiting room meant that this was difficult because they were very close. The reception had a glass screen to separate it from the waiting area. Staff ensured the reception glass screens were closed when answering calls in order to preserve confidentiality. The practice also had a small office available to use for confidential discussions. We observed the reception area also had a portable telephone so staff could take the confidential calls in private.

Staff told us that 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 she would investigate these and any learning identified would be shared with staff. There was a notice in the patient reception area stating the practice's zero tolerance to abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 92% of practice respondents said the GP involved them in care decisions. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt 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. Patient feedback on the comment cards we received was also positive in these areas and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving

Good

Are services caring?

them advice on how to find a support service. We were told that special arrangements had been put into place for dealing with a death of a member of the local Muslim community. The practice had arranged with a senior member of the Muslim community and the coroner's office to be available to issue death certificates (where it was an expected death) and allow the funeral to take place within their religious timeframe. Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations.

We observed there was an information board on the waiting room dedicated to carers. We saw there was written information available for carers to ensure they understood the various avenues of support available to them. There was also information on the website about how to inform the practice if they were a carer. The practice's computer system alerted GPs if a patient was also a carer. The practice told us they supported carers in their role by offering, for example, priority appointments and influenza vaccinations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, in response to the concerns raised about privacy with telephone access for appointments a cordless telephone was purchased. The practice had a statement of intent on their website which informed patients when the practice planned to introduce an online appointment booking facility and electronic repeat prescription service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, services for asylum seekers, those with a learning disability, the unemployed, carers and those patients whose first language was not English. The practice had access to, online and telephone translation services and GPs who spoke more than one language. The practice provided equality and diversity training through e-learning for all staff. Staff we spoke with confirmed that they had completed the equality and diversity training.

The premises and services had been designed to meet the needs of patients with disabilities. There was level access into the practice and parking spaces for patients who were disabled. All GP and nurse consulting rooms were on the ground floor. The practice had wide corridors to enable access for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were shared with another service provider who occupied the rest of the ground floor of the building.

The practice provided services for patients whose circumstances made them vulnerable. The practice kept a register of patients they were aware of who lived in vulnerable circumstances and had a system for flagging vulnerability in individual records. Patients were able to register with the practice irrespective of their circumstances, including those with "no fixed abode".

Access to the service

The practice was open on Monday, Tuesday, Thursday and Friday between 8am-12:30pm and 1:30pm–6pm. On Wednesday from 7:30am-12:30pm and 1:30pm-6pm, and Saturday from 8am-11pm for pre-booked appointments only. The practice nurse operated an early morning clinic on a Wednesday between 7.30am and 8am.

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. 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 about 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 by GPs were made to patients when requested.

Patients we spoke with were generally satisfied with the appointments system. The practice operated a GP triage system. This allowed patients to telephone the practice as usual and their request for an appointment would be passed to a GP who would contact them at an agreed time to assess them (usually within the hour). We were told the value of this system was that every patient who contacted the practice had a medical consultation with a GP who decided on the most appropriate course of action. The system also allowed the practice to target resources and ensure sufficient staff were available at times of greatest demand. The practice reviewed the success of this system for April 2013 and October 2014.The data collected by the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice to date indicated that approximately 52% of consultations did not require a face to face appointment. The practice had a policy that every patient who needed an urgent appointment would be seen even if all appointment slots were filled. Patients also confirmed that they could see a GP on the same day if they needed to do so. We were also given an example of a relative who contacted the practice from another country and had been able to speak to a GP and request a home visit for their relative. We heard the GP had contacted the relative following the visit to share the outcome.

The practice promoted patients to be self caring and take charge of their health. To facilitate this the practice were able to refer patients to other non medical services (called social prescribing). We were given an example of a patient who had been referred to a 12 – week weight loss programme. The website also had information and advice for patients on how to treat minor illness. Patients could be referred for an assessment to use telehealth which used technology to provide services that assist in the management of long term health conditions. The telehealth system enabled individuals to take more control over their own health, by allowing them to monitor vital signs, such as blood pressure, and transmitting the information to a telehealth monitoring center. The results were monitored against parameters set by the individual's GP and flagged up problems or issues before they needed urgent medical attention.

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 process and we saw all comments and complaints were recorded with an outcome for the complaint. 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.

The practice reviewed complaints annually to detect themes or trends. We looked at two complaints received in the last 12 months and found they had been responded to within the timescale, with a written explanation to the patients of the findings of the practice investigation. The practice manager was able to tell us the actions taken in respect of this issue, which showed how lessons learned from individual complaints had been acted upon.

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 manager told us the objectives of the practice were listed in the statement of purpose which is available on the practice website. The objectives included providing the best quality care and service to patients within a confidential and safe environment and to promote good health to patients through health education and good clinical care, both within the practice and the patient's own home.

The practice had been proactive by planning to replace an unsuitable practice building by proposing a new purpose built structure. The new building was planned to be 'future proof' and to provide a wide range of facilities. There was succession planning in place to ensure continuity of patient care when key staff left the practice so as not disrupt the delivery of the service. The practice had undertaken an analysis of the business to identify the threats and weaknesses then formulated a business plans to mitigate these. Members of staff from the practice also participated in the local service planning through organisations such as the Clinical Commissioning Group.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a senior nurse for infection control and a senior partner was the lead person for safeguarding procedures. The members of administrative staff we spoke with all told us there was good communication within the practice, with feedback accepted by the partners and the practice manager. Staff confirmed the senior partner and the practice manager were very approachable and actioned any issues that had been raised with them. We were told by the GPs there was good communication between the team. They had an informal meeting each morning after practice to plan the home visits and also raise any issues or concerns.

The practice manager took lead responsibility for the day-to-day management of the practice. The practice manager acted as a link between the GPs, staff and patients. The practice manager had supervisory responsibility for the nursing team whilst a senior partner provided clinical supervision for the nurses. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other, and this made them more confident about proposing new ways of working. We found that staff were encouraged to develop additional clinical skills and roles.

The practice had minuted partner meetings where developments and new guidance were discussed. We found that responsibility and accountability was very clear among the partners of the practice. The GPs in the practice told us they operated an informal monitoring and mentoring system through their daily informal contact. The senior partner shared responsibilities with the other GPs. The GPs told us they felt complaints were dealt with following the agreed protocols and they tried to work with the patient and be honest when things went wrong so both patient and practice could learn together.

Governance Arrangements

We saw the practice had a range of governance policies and protocols which covered all aspects of the services it provided and these were routinely reviewed and updated to reflect current guidance.

We discussed the arrangements for clinical governance with the GPs. We found that governance was seen as a universal responsibility and there was an expectation staff would share the responsibility for difficult situations through discussion with others. The staff we spoke with were clear about what decisions they were required to make, knew what they were responsible for and fulfilled their role. For example, one nurse took responsibility for checking emergency medicine expiry dates and we saw this check was carried out.

The practice defined clear lines of responsibility for making specific decisions about the provision, safety and adequacy of care at practice level. The practice nurses we spoke with told us that they always referred patients back to the GPs where medical conditions changed and collectively agreed the best course of action to involve and support the patient.

The practice ensured any risks to the delivery of high-quality care were identified and mitigated before they became issues that would adversely impact on patients. The practice actively sought information in order to improve. We saw the practice routinely gathered feedback from patients via suggestions and questionnaires and used this information to improve. We were told by the practice manager they used audits to inform their own governance

Are services well-led?

Good

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

reporting and practice improvement action plans. The practice's website was well maintained and informative, and provided current and potential patients with information about the practice and improvements.

The GPs we spoke with told us they continually reviewed their patient lists, and individual patient records were reviewed at each appointment. GPs supervised and appraised the nursing team and patient care formed part of these reviews. We observed how the reception staff greeted patients and supported them on their arrival at the practice. All staff were made aware they had a responsibility to ensure patient safety was maintained and where concerns were observed in relation to vulnerable patients, these were reported.

The practice managed risk through policies and operating procedures. We read some policies and observed that they were included as part of the induction programme for newly recruited staff. The staff we spoke with demonstrated a good knowledge of policies and protocols. The practice manager told us that any changes were communicated to staff both informally and at staff meetings to ensure they were implemented as soon as possible. The practice manager told us they monitored adherence to these policies.

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

The practice was proactive in gaining patient feedback. The survey showed high levels of patient satisfaction with the practice. The survey had been made available to all patients on the practice's website alongside the actions agreed as a consequence of the feedback.

Patients spoke highly of the practice and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. The practice had established a patient participation group which was used to inform the improvement and development of the practice. The patients we spoke with reported excellent care and treatment from all staff.

The practice had gathered feedback from staff through staff meetings, appraisal and discussions. We spoke with a range of staff including GPs, the practice nurses, the health care assistant the practice manager, and the administrative staff. All the staff we spoke with told us they felt involved in the day to day running of the practice, as well as the longer term functions of the practice. 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 whistle blowing policy which was available to all staff.

The practice evidenced that they had used the feedback provided through the CQC inspection process. We saw that areas of suggested improvement had been acted on, for example, all staff had undertaken some form of training for the safeguarding of children and adults.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Performance was also discussed and reviewed at annual staff reviews. Regular appraisal took place and staff had development plans. Staff told us the practice was very supportive of training and that they had monthly training afternoons where guest speakers and trainers attended. Staff training included mandatory subjects such as basic life support, fire training and safeguarding children and vulnerable adults. Staff told us they felt supported by the practice manager and the partners in the practice, and that the team were approachable and responded well to any queries raised by administrative staff.

The practice routinely considered improvements to their services and used feedback from the patient participation group. There were measures in place to learn from any incidents that occurred within the practice. Where complaints were received about staff or other aspects of the practice, the practice manager spoke with those involved and offered them support to improve their performance. We were told there were sufficient staff on duty at all times to ensure patient needs were met. We were told the practice manager and the senior partner led the management team well.