Queensway Surgery

Quality Report

75 Queensway, Southend-on-Sea,
Essex SS1 2AB
Tel: 01702 463333
Website: www.queenswaysurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

We conducted a comprehensive announced inspection on 11 November 2014 under our new approach to inspecting GP practices.

We found that the practice was providing good outcomes for patients in each of the domains and the overall rating for the practice was good.

Our key findings were as follows:

- The practice had comprehensive systems for monitoring, responding to and learning from incidents when things went wrong.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly. The practice had recently introduced a Proactive Patient Care (PPC) programme to actively encourage patients to attend regular annual and routine health checks and healthcare screening. We saw records that showed that this service had helped to increase the uptake in cervical screening from 62% to 72%. Records we viewed showed that the practice had received praise from the South Essex Partnership University NHS Foundation Trust for improvements in annual health checks for patients who had a learning disability.
- The practice was responsive to the needs of patients and operated a flexible system for routine and health review and promotion appointments.
- The practice was well managed with staff and patients reporting that they felt valued and were involved in making decisions.

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

The provider should:

- Ensure that all staff who carry out chaperone duties undertake appropriate training in respect of their roles and responsibilities.

Professor Steve FieldCBE 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 safe. There were procedures in place that were followed to identify and minimise risks to the safety of staff and patients. Staff understood their responsibilities to raise concerns, and report incidents and near misses. There were processes for learning from incidents and improving patient safety where needed. The practice had suitable policies and procedures, including fire safety and health and safety systems and the premises were maintained to reduce risks to both patients and staff.

The practice had systems in place for assessing risks of health acquired infections and there were policies and procedures in place. These procedures were monitored and improved where needed.

Are services effective?

Good

The practice is rated as good for effective. Data we had access to showed that the practice was achieving results that were in line or better than the national or local Clinical Commissioning Group average, in most areas of assessment and delivery of patient care. Patients' care and treatment took account of National Institute for Health and Care Excellence (NICE) and local guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation.

The practice was proactive in the care and treatment provided for patients with long term conditions such as asthma and diabetes and regularly audited areas of clinical practice. The practice worked in partnership with other health professionals to ensure that patients from hard to reach groups such as homeless people and those with alcohol and substance misuse issues received coordinated care and treatment. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice in line with the local and national averages for most aspects of care. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them.

Summary of findings

We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The majority of patients reported good access to the practice and said that emergency appointments were available the same day. Some patients reported that access to appointments was difficult for those of working age who were unable to attend the practice during normal working hours. The practice had introduced two telephone clinic and triage systems to improve access for these patients.

There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. The practice had undergone some changes within the past year with the senior partner leaving the practice. We saw that the practice had reviewed areas for improvement and were working to achieve these improvements.

There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems. They met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients and this was acted upon. The practice had a newly formed virtual patient participation group (PPG). A patient participation group is a forum made up of patients and staff who share information and help influence changes and improvements in general practices. There was evidence that the practice had a culture of learning, development and improvement. There were plans in place to introduce meetings to develop the PPG further.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and were included on the practice's 'unplanned admissions avoidance' list to alert the team to people who may be more vulnerable. The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments.

At the time of our inspection the practice was in the process of delivering its flu vaccination programme and a 'flu at home' programme to support patients who were unable to attend the practice. A GP and health care assistant visited people in their homes if their health prevented them from attending the clinics at the surgery. They used this opportunity to carry out basis health checks and to identify any support patients needed, making appropriate referrals to other agencies including social services. The practice worked with a number of local care homes to provide a responsive service to the people who lived there.

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

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice

annual and half yearly reviews of their health. Appointments were available with the practice nurses for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed longer appointments and home visits were available. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

People whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses who arranged visits to them at home (including patients in the local care home the practice supported). Patients told us they were seen regularly to help them manage their health.

Summary of findings

Families, children and young people

Good

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

Information and advice was available to promote health to women before, during and after pregnancy. Expectant mothers had access to midwife clinics every week. The practice monitored the physical and developmental progress of babies and young children. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect.

Records showed that looked after children, those subject to child protection orders and children living in disadvantaged circumstances were discussed, any issues shared and followed up at monthly multi-disciplinary meetings. The GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations, sharing information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Appointments for childhood immunisations were available at times to suit patients and the practice was performing in line with the local Clinical Commissioning Group (CCG) average for childhood immunisation and vaccination programme.

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was aware of the difficulties working aged people had in accessing appointments during normal working hours and had introduced two telephone consultation systems to help provide access to patients from this population group.

Appointments could be booked in person or by telephone. Appointments could be booked up to four weeks in advance. The practice offered appointments up to 6pm and pre-booked afternoon telephone consultations with the GP's were available each day.

Summary of findings

Information about annual health checks for patients aged between 40 and 74 years was available within the practice and on their website. Nurse led clinics were provided each week for well patient health checks. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the various vaccinations available including diphtheria, tetanus, polio, and hepatitis A was available on the practice website.

When patients required referral to specialist services they were offered a choice of services, locations and dates.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice recognised the needs of people who were vulnerable such as homeless people, those with depression, alcohol or substance misuse issues, people with mental health conditions and those with learning disabilities.

All patients with learning disabilities were invited to attend for an annual health check and staff worked proactively to improve the uptake of these checks. The practice worked with local agencies including social services, homeless charities and groups and the police to help identify and safeguard people who were vulnerable.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check.

The practice had a lead GP for overseeing the treatment of patients who experienced poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

Summary of findings

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

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 41 CQC comment cards patients had filled in. The majority of patients who completed comment cards told us that they were satisfied with the service they received. They commented that staff were kind, caring and helpful. Some patients told us that it was very difficult to make appointments, particularly for those who were of working age and this meant that they needed to take time off work to see a GP.

We also spoke with nine patients on the day of our inspection, six of whom was involved with the practice Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all staff who carry out chaperone duties undertake appropriate training in respect of their roles and responsibilities.

Outstanding practice

- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly. The practice had recently introduced a Proactive Patient Care (PPC) programme to actively encourage patients to attend regular annual and routine health checks and healthcare screening. We saw records that showed that this service had helped to increase the uptake in cervical screening from 62% to 72%. Records we viewed showed that the practice had received praise from the South Essex Partnership University NHS Foundation Trust for improvements in annual health checks for patients who had a learning disability.

Queensway Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Queensway Surgery

Queensway Surgery is located in the heart of Southend on Sea. The practice provides services for approximately 23,000 patients living in the area. The practice has a branch surgery on Sutton Road, Southend on Sea. The branch surgery was not inspected.

The practice is managed by five GP partners. The practice employs six salaried GPs, one nurse practitioner, six practice nurses and a team of administrative and reception staff who support the practice.

The practice is open between 8am and 6pm on weekdays. GP appointments are available from 8am to 12.30pm, and 2pm to 6pm and nurse led appointments between 9am and 12.30pm, and 2pm to 5pm. The practice offers two telephone consultation systems, one pre-bookable afternoon clinic which is for medication reviews, blood test results and follow-ups. The second is a telephone triage system dealing with requests for home visits. Home visits are available as required based upon need.

Details of how to access out-of-hours emergency and non-emergency treatment and advice was available within the practice and on its website.

Why we carried out this inspection

We inspected Queensway Surgery as part of our new comprehensive inspection programme.

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- 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

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 November 2014. During our visit we spoke with a range of staff including GP's, practice nurses, reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

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

Complaints, accidents and other incidents such as significant events were reviewed regularly to monitor the practice's safety record and to take action to improve on this where appropriate. We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice has a system in place for reporting, monitoring and learning from significant events. Accidents, significant events and any other safety incidents were fully investigated and a root cause analysis was carried out to help determine a timeline of events and what had gone wrong. Following each investigation any areas for change in practices were identified, shared with staff and reviewed periodically to ensure that risks to patients and staff were minimised.

Records were kept of significant events that had occurred during the last 12 months and these were made available to us. All ongoing significant events, concerns or complaints of a serious nature were discussed with staff during the weekly practice meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Investigations into safety incidents were reviewed periodically to ensure that staff learning was embedded in practice and patient safety was improved. For example we saw evidence of learning and improvement to the procedures for ensuring that appropriate referrals were made to specialists following a delay in referral for one patient. We also saw that following a serious case review that changes were made to the procedures for reviewing repeat prescriptions for patients who were prescribed antidepressant medicines.

Staff, including receptionists, administrators and nursing staff, told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved. All staff we spoke with were aware of and could tell us of changes that had been implemented following serious or significant incidents.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Practice training records made available to us showed that some staff had received relevant role specific training on safeguarding adults and children. Training was planned for those members of staff who were yet to undertake this training. Staff we spoke with told us that they had access to the practice and local safeguarding protocols and they were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had a designated lead for safeguarding vulnerable adults and children. The lead person had oversight for safeguarding vulnerable patients and acted as a resource for the practice. Staff we spoke with were aware of whom the lead was and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example looked after children or those children who were subject to child protection plans, elderly patients, homeless people

and those who had learning disabilities. The safeguarding lead had experience in treating patients with history of self-harm, alcohol and substance misuse, patients in the prison system and ex-offenders. Extended appointments and telephone consultations were available and the practice worked closely with local agencies and the police to help identify patients at risk and to help ensure that there was a coordinated approach to safeguarding patients. Vulnerable families, adults and children were discussed at weekly GP meetings and monthly multidisciplinary team meetings which were attended by health visitors, district nurses and school nurses. We looked at the records from these meetings and found that information was shared with the relevant agencies such as social services, health visitors and where appropriate the police, and appropriate referrals were made The GP partners told us that as part of their proactive approach to supporting older people who were housebound, they were assessing these patients' needs for additional support when visited patients to administer flu vaccinations.

A chaperone policy was in place and visible in the waiting areas noticeboard and in consulting rooms. Staff we spoke with were aware of the policy and procedures for chaperoning patients. Through discussion with staff and a review of training records we found that staff had not undertaken training in respect of their role when chaperoning patients. Staff we spoke with told us that this was planned as part of a review of training needs.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on the practice electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that staff had undertaken training in the use of the electronic system and audits had been carried out to assess the completeness of these records. Action had been taken to address any shortcomings identified.

Medicines Management

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

The practice followed national guidelines around medicines prescribing and repeat prescriptions. We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for hypnotic medicines was similar to the national average. The practices' performance around prescribing of non-steroidal anti-inflammatory drugs (NSAID's) was lower than the local Clinical Commissioning Group (CCG) average. The use of some NSAID's such as Diclofenac is contraindicated in patients who have cardiovascular or peripheral vascular disease (narrowing of peripheral arteries). A clinical audit was carried out in September 2014 to monitor the use of NSAID's for this patient group. As a result of the audit Diclofenac was removed from the repeat prescription list for all relevant patients and a medical alert system was set up in patient's records. The results and outcome from the audit were shared with all clinical staff including nurses and locum GPs.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed leaflets and posters, and on the practice website. Patients could order repeat prescriptions in person, by fax or by post. There were appropriate systems in place for ensuring that patients repeat prescriptions were checked and that patients' blood levels were routinely monitored to ensure that medicines were prescribed safely and effectively. Following a serious case review, changes had been introduced to increase the frequency of reviews for patients who had repeat prescriptions for antidepressant medicines. The practice was actively working with the local Clinical Commissioning Group (CCG) medicines management team to improve patient safety and to help educate patients on medicine reviews and repeat prescriptions.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. The majority of patients we spoke with and those who completed comment cards told us that that the repeat prescription service worked well and they had their medicines in good time. They also confirmed that their prescriptions were reviewed and any changes were

explained fully. Some people reported problems with obtaining their prescriptions in a timely way. The GPs told us that they were introducing electronic prescribing early in 2015 to help deal with these problems.

Cleanliness & Infection Control

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

We saw there were cleaning schedules in place for general and clinical areas and cleaning records were kept. There were infection control policies and procedures for staff to follow, which enabled them to plan and implement control of infection measures. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. Advice and information was provided so as to help patients protect themselves against the risks of infections. All clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

The practice had a lead for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy. An infection control audit had been conducted in November 2014. This included an audit of infections associated with minor surgical procedures. From the audit areas for improvements were identified, including provision of advice and information to patients around activities to avoid following minor surgery. An action plan was developed to review improvements.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales, thermometers and emergency equipment such as an automatic external defibrillator (used to attempt to restart a person's heart in a cardiac emergency) were periodically checked and calibrated to ensure accurate results for patients. Records we viewed showed that equipment had been portable electronic appliance (PAT) tested. They told us that visual checks were carried out on all equipment to help identify any defects or safety issues. PAT testing is an examination of electrical appliances and equipment to ensure that they are safe to use. Most electrical defects can be found by visual examination but some types of defect can only be found by testing.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. Employment references and criminal records checks were obtained for all newly appointed staff before they started work at the practice. A number of staff who had worked at the practice for some years did not have criminal records checks. We saw that these were being sought and copies of applications were seen in staff files. There were procedures in place for managing under-performance or any other disciplinary issues.

The GP partners told us that they were actively seeking to recruit more GPs to help meet the needs of the 24,000 patients they had registered with the practice. To date, despite local and national advertising for the vacant positions they had been unable to recruit. The GP's discussed with us the measures they had to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. These included maximising

Good

Are services safe?

GP time through the implementation of telephone triage consultations and a daily afternoon telephone clinic, and ensuring that no more than two partners took leave at any one time. There were arrangements in place to ensure that extra staff were employed if required to deal with any changes in demand to the service, as a result of both unforeseen and expected situations such as seasonal variations (winter pressures), or adverse weather conditions. Staff told us that locum cover was arranged or staff would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, which staff were aware of. Risk assessments, which were monitored and audited, were in place to ensure that the practice environment, equipment and staff practices were safe.

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with medical emergency situations. We saw records showing all staff had received training in basic life support. Staff had access to Resuscitation Council (UK) guidelines to assist in dealing with medical emergencies. Emergency equipment and medicines were available at a dedicated place within the practice, including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in a cardiac emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (allergic reactions) and hypoglycaemia (low blood sugar). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

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 their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information, new guidance and changes to current guidelines were made available in information folders. These were shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments. We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs.

The practice GPs and nurses took lead roles in specialist clinical areas such as diabetes, heart disease, respiratory diseases, asthma and mental. The practice nurses provided clinics for reviews of patients with long term conditions, well person, asthma and diabetic clinics. This helped the GPs to treat patients with more complex medical conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. The practice operated an 'open access' policy for treating patients who were homeless to help ensure that they were seen promptly.

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. The GPs told us clinical audits were often linked to medicines management information, and safety alerts. We saw that the practice used relevant data to help inform which areas to audit. We saw that an audit had been carried out around the use of non-steroidal anti-inflammatory drugs (NSAID's). These medicines are used in the treatment of inflammatory conditions such as arthritis and for pain management. As a result of the audit changes were made in the prescribing of these medicines for some groups of patients.

We looked at the data and information we had about the practice. This included information taken from the Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was in line with or higher than the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as diabetes, dementia, learning disabilities and mental health disorders and those with life limiting conditions.

The practice had recently introduced a Proactive Patient Care (PPC) programme to actively encourage patients to attend regular annual and routine health checks and healthcare screening. We saw records that showed that this service had helped to increase the uptake in cervical screening from 62% to 72%. Records we viewed showed that the practice had received praise from the South Essex Partnership University NHS Foundation Trust for improvements in annual health checks for patients who had a learning disability.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Staff described the process for ensuring that repeat prescriptions were checked and reviewed and the processes for alerting the GP's if they had any concerns about repeat prescriptions. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of alerts the GPs reviewed the use of the medicine in question, prescribed alternatives or, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs and reviewed their treatments appropriately.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

The practice employed staff who were appropriately skilled and qualified to perform their roles. Appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for four members of staff. We saw evidence that all staff were appropriately qualified and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw that clinical staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration.

GP partners told us that historically training for staff at the practice had not been adequate. For example, there were no arrangements in place for annual appraisal for reception and administrative staff. They told us that improvements had been made including an annual appraisal system for all staff. Records we looked at showed that staff performance was appraised and that members of staff had personal learning and development plans which reflected their roles and responsibilities within the practice. Staff we spoke with told us that they had access to training opportunities and that they were able to access 'Time to Learn'. This is time when GPs have no patients to see and use the time for learning and training. Nursing staff told us that they received regular clinical supervision, support and advice from the GPs when needed. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

We saw that all new staff underwent a period of induction to the practice. There were tailored induction packs to support new staff according to their role and job description. Support was available to all new staff to help them settle into their new role and to familiarise themselves with relevant policies, procedures and practices. Staff we spoke with including the nurses and GPs told us that the induction process was effective. They told us that there was a 'buddy' system whereby they received support and mentorship from more senior colleagues when they first started work at the practice.

Working with colleagues and other services

The practice worked with other service providers, including social services, the local hospital trust and community services to meet patient's needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

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

The practice showed that they were proactive in identifying patients who were vulnerable or at risk of harm, including self-harm. Through discussions with staff and a review of records we saw that the practice worked closely with the local safeguarding team, homeless charities and the police to provide effective support to these patient groups.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. Staff told us that information was accessible to help them make decisions and to plan and deliver effective care and treatment.

There was a system for making sure test results and other important communications about patients were dealt with. The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, such as those receiving end of life care. We saw that treatment records for patients who had used the out-of-hours service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment

The GPs and nurses at the practice worked closely with Macmillan nurses and other agencies who support people with life limiting illnesses. They held a monthly palliative care meeting with other doctors, nurses, healthcare

Good

Are services effective?

(for example, treatment is effective)

assistants and MacMillan nurses attending to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs.

Staff were alert to the importance of only sharing information with patients or with patients' consent and gave us an example of a situation where a receptionist had checked a request with a GP.

Consent to care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients consent before carrying out physical examinations or providing treatments. Both nurses we spoke with were aware of parental responsibilities for children and they told us that they obtained parental consent before administering child immunisations and vaccines. We saw that during the course of an infection control audit, staff had identified a small number of patients whose consent to minor surgical procedures had not been recorded. This had prompted an audit of consent procedures and patient records and this was planned in the near future.

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

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room, reception and entrance hall where patients could see them. These included information to promote good physical and mental health and lifestyle choices. We saw information about promoting and maintaining physical and mental health, domestic violence advice and support was prominently displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation, alcohol consumption and substance misuse. There was information available about the local and national help, support and advice services. This information was available in written formats within the practice and on the practice website.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Nurse led clinics and pre-booked appointments were available including sexual health, family planning and menopausal advice, heart disease prevention, diabetic and asthma clinics.

Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Data we looked at before the inspection showed that the practice was performing in line with other practices in the area for take up of childhood immunisations.

We saw that the practice had received commendations from local secondary health providers for their proactive approach to promoting chlamydia screening.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 41 CQC comment cards that patients had completed and spoke in person with nine patients, six of whom were involved with the Patient Participation Group (PPG). A patient participation group is a forum made up of patients and staff who meet to share information and help influence changes and improvements in general practices. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. The patients said they felt the practice provided excellent care and treatment. Patients commented that staff were kind, efficient, helpful and caring. They said staff listened to them sympathetically and were respectful and treated them with dignity.

We reviewed the most recent information available from the national patient survey, which was carried out in 2013. The results were based upon a 34% response rate of 397 patients who were invited to participate in the survey. This showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example 88% of patients who completed the survey said that their GP was good at listening to them and 86% said that their GP was good at treating them with care and concern. However the practice scored worse than the national average for proportion of patients who would recommend their GP. The GP partners told us that they were aware of the issues faced by the practice and they had plans in place to make improvements to the service. The practice planned on closing their patient list for a period of time during which they would not register any new patients. This time would be used to implement the improvements needed. The practice had conducted a patient survey in 2014 to gain patients views about the closure and the response had been overwhelmingly positive with 93% of patients in agreement with the planned proposal. This demonstrated that the practice was taking patients views on board and there were plans in place to improve patient's experience.

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

There were signs in the waiting areas and consulting rooms explaining that patients could ask for a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so.

The practice was located in a two storey purpose built premises and was easily accessible to patients with mobility issues. Waiting areas and corridors were spacious affording wheelchair users and parents with prams and pushchairs room to navigate. Consultation rooms situated on the first floor were accessible via a passenger lift. There were hearing loop facilities for patients who were hearing impaired.

The practice had a range of anti-discrimination policies and procedures and staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager and GPs told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act 2005 and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

Information was available to patients in respect of Summary Care Records (SCR). These are electronic patient records such as medicines prescribed; known allergies and that are held on a central NHS computer system and are

Good

Are services caring?

used to assist health care professionals such as out of hour's providers to treat patients in an emergency situation. Patients were advised as how they could opt out of this system if they wished to.

The patient 2013 national GP survey information we reviewed showed patients responded less 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, 64% of practice respondents said the GP involved them in care decisions and 74% felt the GP was good at explaining treatment and results. These results were lower than the local and national averages. The practice had undergone some changes within the previous year and the senior partner had left the practice. GP partners we spoke with during the inspection demonstrated that they were committed to improving the services provided to patients and they had plans in place as to how this was to be achieved. These included closing the patient list and increasing staffing levels. Patients we spoke with during the inspection told us that nurses and GP's were extremely caring and spent time ensuring that they understood their treatment.

Patients we spoke to on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that information in relation to their health and the treatment that they received was explained to them in a way that they would understand. Patient feedback on the comment cards we received was also positive the majority of the 41 patients who responded told us that they were happy with their involvement in their care and treatment.

There were arrangements in place to support patients whose first language was not English. Staff told us that access to translation services were available for patients who did not have English as a first language. We saw that the self-service check system had translation facilities and the practice website could be translated into a number of languages, which reflected the diverse population groups in Southend including Albanian, Chinese, Polish and Hindi.

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were invited to complete a 'carers registration' so that they could be identified and provided with information and support to access local services and benefits designed to assist carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families.

The practice website included information for bereaved people, including practical information including making funeral arrangements and registering deaths. Staff told us families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation the practice or a home visit where this was more appropriate. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including vulnerable and homeless people and those with dementia, mental health conditions, learning disabilities or life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients.

The practice provided general practice services to a number of patients who were living in care homes. We spoke with the managers of three care homes about the service people received from Queensway Surgery. Both were positive about the service. They told us that the GP was polite, respectful and kind to their patients and listened to them. Managers confirmed that the GP worked with them to review each person's health and medicines.

A number of patients we spoke with and those who completed comment cards within the working age population group told us that it was difficult to get appointments at times that suited them. In response to this the practice had recently introduced a telephone clinic system offering 25 pre-booked consultations every afternoon. These telephone clinics were used to deal with blood test results, medication reviews and follow up consultations with patients who were well known to the GPs. In addition the practice provided a GP led telephone triage to deal with requests for home visits. Both telephone systems had helped to generate up to an extra 75 appointments each week.

Tackling inequity and promoting equality

The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The GP partners told us that the practice had improved the coding systems to identify patients who required extra support such as patients who were housebound, those who had learning disabilities, dementia, mental health conditions including depression, homeless people or those with alcohol or substance misuse problems. The practice had introduced a Proactive Patient Care initiative to improve patient uptake for annual health checks and routine screening checks. Staff focused on particular groups to invite patients to attend appointments. We saw evidence that this had resulted in an increase in patients receiving their annual health checks and health promotion screening such as chlamydia screening.

The practice recognised the needs of older people who were confined to their houses. They had commenced a 'flu at home' programme, visiting patients initially who lived in the local tower block accommodation to administer flu vaccinations. GP's told us that they were using these home visits to opportunistically carry out health checks (blood pressure and pulse checks) and to identify patients who would benefit from support from other agencies such as social services or community occupational services. Staff told us that they were also using the visits as opportunities to distribute the local Lions Club 'message in a bottle'. The 'message in a bottle' is a simple way that patients can store personal and medical information on a standard form and in a common place, so that medical professionals can access this in the case of an emergency.

The practice recognised the needs of hard to reach groups such as people who were homeless or those with alcohol or substance misuse problems. One of the GP's working at the practice had experience of treating such patients and recognising their needs and the support they needed. We saw that they practice had an 'open access' approach to supporting patients from these hard to reach population groups and offered a flexible appointment and telephone consultation service. The practice also worked closely with local social services and homeless charities to help deliver safe accessible coordinated patient care.

Patients who needed extra support because of their complex needs were allocated longer appointments and had access to telephone consultations. We saw specific tailored care plans to meet their needs for example patients with learning disabilities or those who suffered with dementia as well as those with long term medical conditions.

Access to the service

Staff at the practice understood the needs of the practice populations and had developed an appointment system to meet the needs of patients from the different population groups. Details of the services available, how to book, change or cancel appointments were posted throughout

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice and displayed on the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. Routine appointments could be pre-booked up to four weeks in advance. Staff showed us the arrangements for monitoring the availability of appointments and non-attended appointments. These were reviewed weekly to help ensure that patients were provided with a flexible and reliable appointment system.

A number of patients we spoke with and those who completed comment cards within the working age population group told us that it was difficult to get appointments at times that suited them. In response to this the practice had recently introduced a telephone clinic system offering 25 pre-booked consultations every afternoon. These telephone clinics were used to deal with blood test results, medication reviews and follow up consultations with patients who were well known to GP's. In addition the practice provided a GP led telephone triage to deal with requests for home visits. Both telephone systems had helped to generate up to an extra 75 appointments each week. At the time of our inspection the practice did not offer extended hours as this was not possible due to the staffing levels.

The practice is located in a two storey purpose build premises. Consultation rooms on the first floor were accessible via a passenger lift. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

There was clear written information available to patients, which described the complaints process and how they could make complaints and raise concerns. This information included details of the timelines for investigating and responding to complaints and concerns. This information was available within the practice and on the website. Patients were advised what they could do if they remained dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman, a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Staff were aware of these procedures and the designated person who handled complaints. Doctors, nurses and administrative staff told us that the practice had an open culture where they felt safe and able to raise concerns. They told us learning from complaints and when things went wrong was shared through meetings and that there were mechanisms in place for making improvements as needed to help minimise

We looked at the records for the complaints received in the last twelve months and found these were investigated thoroughly and sensitively. All complaints were recorded and investigated consistently in line with the practice's complaints procedures. Records we viewed showed that there were learning outcomes from complaints and that these were shared with staff during practices meetings to help improve practices and patient care.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The practice ethos was to put patients' needs at the heart of everything they did. Staff we spoke with were aware of the vision, values and future plans for the practice. There had been changes to the partnership arrangements within the past year, with the senior partner leaving the practice. There had been a number of more recent improvements within the practice including staff training and development and a more proactive approach to the assessment of patients' needs and the delivery of patient care.

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

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that they were aware of their roles and responsibilities within the team. The majority of staff had lead roles, these included infection control, palliative care and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication. All staff we spoke with reported that the practice was moving forward and improving.

The practice had recently introduced monthly clinical meetings and discussions were held about any significant event analyses (SEAs) that were ongoing or completed. All of the clinical staff attended these meetings and where relevant other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working in practice. The practice had robust systems for monitoring and reviewing the delivery of patient care and treatment.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. Quality Outcomes Framework (QOF) system ispart of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. We saw examples of completed clinical audit cycles demonstrating that the practice was reviewing and evaluating the care and treatment patients received.

Leadership, openness and transparency

There was a clear leadership structure within the practice with named members of staff in lead roles. All staff we spoke with told us that all members of the management team were approachable. They were encouraged to share new ideas about how to improve the services they provide. Staff spoke positively and passionately about the practice and how they worked collaboratively with colleagues and health care professionals. Staff told us that they felt very well supported within the practice. They told us that the practice was well managed. They told us that there was an open and transparent culture within the practice. Both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held a short team meeting each morning before surgery started to discuss and plan their day.

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

The practice had a newly introduced virtual Patient Participation Group (PPG). A virtual PPG is an online community of patients who work with the practice to discuss and develop the services provided. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. We spoke with six members of the Patient Participation Group and they told us they were able to help inform and shape the management of the practice in

Are services well-led?

Good

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

relation to patient priorities, any planned practice changes and the outcomes from local and nation GP survey. There were plans in place to develop the Patient Participation Group further and to hold face-to-face meetings. Patients we spoke with told us that they were aware of the patient group and how they could join or participate. Those who were unable to be part of this group told us that they were always listened to by staff at the practice. The practice website offered patients opportunities to make comments about the service and information was also displayed within the practice.

We looked at the comments and reviews made by patients on the NHS Choices website. A number of negative comments were made about difficulties in getting appointments and obtaining repeat prescriptions. We saw that in each incident the practice manager had responded to comments made and invited the reviewers to meet with them to discuss the issues.

The GP partners told us that in order to make and imbed improvements in the practice that they had made a request to NHS England and the Clinical Commissioning Group to close their patient list. Prior to making this request patients were asked to complete a survey and give their opinions about the proposal. We saw that 93% of the 569 patients who responded to the survey agreed with the proposed closure of the list.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality patient care. We saw that there were robust arrangements for learning from incidents, significant and serious events and complaints. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

Records showed that clinical and other audits were carried out as part of their quality improvement process to improve the service and patient care. Completed audit cycles showed that changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

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