All Saints Surgery

Quality Report

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Date of inspection visit: 6 October 2014
Date of publication: 11/12/2014

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 6 October 2014 as part of our new comprehensive inspection programme. This provider had not been inspected before.

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

. Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice was responsive to the differing needs of its patient population. It had taken particular steps to support its large number of diabetic patients.
- Evidence we reviewed demonstrated that most patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

We saw one area of outstanding practice:

The practice had adapted standard dementia memory tests for use with its Asian population. They had done this by including familiar Asian names and references in the test.

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

The provider should:

- Ensure that audit cycles are completed.
- Improve its recruitment process to ensure that pre employment checks are completed in a timely way and that a robust audit trail is created.
- Update the information it holds about children who are known to be at risk.
- Review the emergency equipment and drugs it holds in the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Summary of findings

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. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. There needed to be better oversight of the practice's emergency equipment. The practice needed to update the information it held about children who identified as at risk. Recruitment procedures were not always robust and not all pre employment checks were made in a timely way.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Care and Health Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. There was evidence of some audits having been started but none had been completed. We saw no evidence that audit was driving improvement in performance for patient outcomes. Multidisciplinary working was reportedly taking place but record keeping was limited or absent.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these are identified. Patients reported good access to the practice and a named doctor and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was limited evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear mission and values statement. Staff were clear about 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 procures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active virtual patient participation group (PPG). All staff had received inductions and nearly all staff had received regular performance reviews and attended staff meetings.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection. They described the staff as respectful, nice, and helpful. Patients also told us that they were involved in decisions about their care and treatment, and that they were treated with dignity and respect. We collected 30 Care Quality Commission comment cards from a box left in the surgery in the week before our visit. The comments on the cards were overwhelmingly positive. Two patients commented that it could sometimes be difficult to get an appointment. Over 350 patients responded to the practice's own most recent survey. The results were very positive. Over 90% of the practice's patients who responded said they would recommend the practice to a friend.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that audit cycles are completed.
- Improve recruitment processes to ensure that pre employment checks are completed in a timely way and that a robust audit trail is created.
- Update the information it holds about children who are known to be at risk.
- Review the emergency equipment and drugs it holds in the practice.

Outstanding practice

The practice had adapted standard dementia memory tests for use with its Asian population. They had done this by including familiar Asian names and references in the test.

All Saints Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor, and a second CQC inspector.

Background to All Saints Surgery

All Saints Surgery provides a range of primary medical services to just over 7,000 patients from purpose built premises situated at 28 All Saints Road, Burton on Trent.

There is currently one GP partner at the practice and a second fixed income partner. There is also a salaried GP. There are two practice nurses and a health care assistant based at the surgery. There are a total of 28 GP sessions each week and ten sessions held by the practice nurse. Some of the sessions are longer than standard GP sessions allowing more patients to be seen each day.

The practice has opted out of providing out-of-hours services to their own patients. Out of hours care is provided by a separate organisation.

Why we carried out this inspection

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

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Clinical Commissioning Group and NHS England to share what they knew. We carried out an announced visit on 6 October 2014. During our visit we spoke with a range of staff and spoke with patients who used the service. 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 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

Detailed findings

- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve 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. For example, we saw how an incident involving a child who received two vaccination injections by mistake was openly reported and reviewed.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. 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 had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting was held when necessary 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 and felt encouraged to do so.

We saw incident forms were readily available on the practice intranet. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, we saw how measures had been put in place to prevent another child receiving two vaccination injections following the incident recorded above.

National patient safety alerts were received by each individual doctor at the practice. We saw how one doctor had taken appropriate action in relation to one recent alert.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults.

Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children who could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

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 appointments. For example, a pop up alert appeared whenever staff accessed the records of children subject to child protection plans. However, the practice did not always update its information when the child protection plan was removed.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants.

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

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy 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.

Good

Are services safe?

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

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 who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. 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 who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and thereafter annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings 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.

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. Staff told us that they had received training in hand washing techniques.

Equipment

Clinical staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing & Recruitment

Not all the records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, we were not able to see evidence that references had been obtained or a criminal records check had been obtained via the Disclosure and Barring Service (DBS) for a recently appointed nurse. We were told that the checks had been taken but the paperwork was missing. We were subsequently provided with a copy of one reference for the nurse in question. We were subsequently told that the practice had relied on a six month old DBS check carried out by the nurse's previous employer. We were sent evidence after the inspection that the practice had obtained an up to date check on the individual. The practice had a recruitment policy that set out the standards it should follow when recruiting clinical and non-clinical staff. The practice had not followed its own procedure in the one case we looked at.

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 was 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 usually 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 were in line with planned staffing requirements.

Good

Are services safe?

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included 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.

Identified risks had been assessed, and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at team meetings. For example, the practice manager had shared the recent findings from a disability access audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. The stock included some additional equipment not required by regulations. Some of this additional equipment was out of date or incomplete.

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, and other medical emergencies. There were preloaded anaphylaxis injection pens containing both adult and paediatric doses. 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 business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

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. We saw minutes of practice meetings where new guidelines were discussed. 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 led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions.

We saw data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The practice used the choose and book system to refer patients for further investigation and treatment.

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

Management, monitoring and improving outcomes for people

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

The practice showed us six clinical audits that had been undertaken in the last year. Those that we reviewed included audits of stroke prevention in atrial fibrillation and a study of diabetic patients with poor symptom control. None of these were completed audits where the practice was able to demonstrate that changes made had improved health outcomes for patients.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 92% of patients with a diagnosis of dementia had received an annual care review. This was above the national average. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. 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 an alert the GPs had reviewed the use of the medicine in question and 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.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending the practice's mandatory courses such as annual basic life support. All the GPs were up to date with their annual continuing professional development requirements and had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller

Good

Are services effective?

(for example, treatment is effective)

assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. Staff told us that they felt well supported.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and asthma. The senior nurse had received extensive additional training in the management of diabetes in order to be able to support the higher than average number of patients at the practice with the condition.

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, out of hours providers and the 111 service were reviewed by a doctor. 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. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents and in particular those with end of life care needs. These meetings were attended by district nurses, palliative care nurses and practice staff. Staff felt this system worked well.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a timely manner. Electronic systems were also in place for making referrals. (The choose and book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record known as EMIS was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. 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

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff understood how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and offered these patients an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients.

The practice had a higher than average number of patients with diabetes. All clinical staff at the practice had undertaken additional training in the management of diabetes. The practice carried out monthly audits to ensure that all patients were having regular blood tests. Test results were closely monitored. Where necessary, the practice called upon external experts to support them in the management of their most challenging diabetic patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was about average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 353 patients undertaken by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. In the national survey, 86% of respondents said they usually waited 15 minutes or less after their appointment time to be seen

Thirty patients completed a CQC comment card to provide us with feedback on the practice. The overwhelming majority were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six 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. Disposable curtains were provided in most consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. One treatment room did not have any privacy curtails or screens. The room was used for carrying out smear tests. The nurse told us that they always locked the door during treatment. Although no patients complained about this, the provider may wish to review this practice. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

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

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

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 most recent practice survey showed ?% of respondents said the GP involved them in care decisions and 79% also felt the GP was good at explaining treatment and results. The results from the national GP survey were less positive as 72% of respondents said they were sufficiently involved in making decisions about their care.

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 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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations. The practice's computer

Good

Are services caring?

system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. The staff told us that doctors regularly attended the funerals of patients who had died when relatives requested this.

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The local Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

We were shown an action plan for addressing concerns expressed by patients in the practice's own annual survey. The practice had introduced a dedicated phone line for patients with medication queries to free up appointment lines. The practice had also introduced bookable telephone appointments in response to patient demand.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The prevalence of patients with a diagnosis of diabetes on the practice list was twice the national average. All clinical staff at the practice had undertaken additional training in the management of diabetes. The practice carried out monthly audits to ensure that all patients were having regular blood tests. Test results were closely monitored. Where necessary, the practice called upon external experts to support them in the management of their most challenging diabetic patients.

The practice had adapted standard dementia memory tests for use with its Asian population. They had done this by including familiar Asian names and references in the test.

The practice had access to online and telephone translation services. The GP and practice manager spoke several Asian languages.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The premises were suitable for the needs of patients with disabilities. The practice was all on one level and there was a ramp at the entrance. A hearing aid loop was installed to assist patients with hearing difficulties.

Appointments were available from 8am to 11.30am and from 3.30pm to 6.30pm on weekdays, and from 8am to 12 noon on Saturdays.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book routine appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's extended opening hours on Saturday mornings was particularly useful to patients with work commitments.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated

Good

Are services responsive to people's needs?

(for example, to feedback?)

responsible person who handled all complaints in the practice. The practice manager was related to the senior partner so complaints were handled by another member of staff to avoid any potential conflict of interest.

We saw that information to help patients understand the complaints system was available on the practice website and in the practice leaflet. A summary of the process was displayed in the waiting room. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

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

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt 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 did not have a formal written strategy to deliver high quality care and promote good outcomes for patients. The priority for the practice was to recruit two additional GPs to fill current vacancies. This was proving difficult for the practice. We were told that in the interests of good continuity of care, the remaining three doctors were working additional sessions to reduce the need to use locums. The senior partner cited this approach as evidence of the practice ethos of patient centred care.

The practice had an aims and values statement which staff were familiar with. The practice's stated aim was to provide the best possible care in a caring, courteous, compassionate, supportive and cost effective manner. The practice values included compassion, respect and holistic care.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff were alerted by email when policies changed. Significant changes were also discussed at practice meetings.

The practice held monthly governance meetings. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at clinical meetings and actions plans were considered to maintain or improve outcomes.

The practice had carried out a number of clinical audits although none of these had yet been completed. Examples of audits we saw included efforts to identify patients at risk of dementia, medicines management reviews and immunisation uptake.

Although the practice did not have formal arrangements for identifying, recording and managing risks, it had identified the risks associated with operating with two GP vacancies. Measures had been discussed and put in place to mitigate these risks.

Leadership, openness and transparency

Although there was not a formal leadership structure there were identified leads for key roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. The single partner took on responsibility for most lead roles in the temporary absence of other partners. All the staff we spoke with told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, although the notes were fairly basic. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and induction policy which were in place to support staff. A staff handbook was available in electronic form and this included sections on equality and diversity and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through an annual survey. We looked at the results of the annual patient survey and found that most patients were satisfied with the service they received. The practice had developed an action plan in response to comments made by patients in the survey. For instance, in response to patient demand, the practice had introduced bookable telephone appointments, a new dedicated telephone line for medication queries and had increased publicity about Saturday morning surgeries.

The practice had an active virtual patient participation group (PPG) with 140 members. The practice told us that repeated attempts to create a PPG that actually met as a group had not been successful. The practice had shared the results of the most recent patient survey with the virtual PPG and sought their reaction to it.

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.

Are services well-led?

Good

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

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two 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 their training needs.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. For example we saw evidence that an incident involving a potential medication error and a community matron had been reviewed and discussed at a practice meeting to ensure that it did not happen again.