The Hall Practice

Quality Report

Hampden Road
Chalfont St. Peter
Gerrards Cross
Buckinghamshire
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Good ●
Are services well-led?	Good ●

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of The Hall Practice, Hampden Road, Chalfont St. Peter, Gerrards Cross, Buckinghamshire, SL9 9SA. The practice had been inspected in 2013. However, this was the first inspection under the new CQC comprehensive inspection approach and was undertaken to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Overall the practice is rated as outstanding. It delivers outstanding effective and caring services and services to the population groups of patients with long term conditions and those in circumstances that may make them vulnerable are also outstanding. The practice is rated as good delivery of safe and responsive services and for being well led.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them. Patient feedback on the care they received was consistently positive and patients commented that they were partners in making decisions about their care and treatment.
- The practice had adequate facilities and was well equipped to treat patients and meet their needs. The practice recognised they needed additional space in which to treat patients and plans were in place to move to larger premises.
- Information about how to complain was available and easy to understand.
- The appointments system was flexible and patients reported no problems in accessing appointments with their named GP. Patients and staff were positive about the benefits of a named GP giving continuity of care.
- The practice was clean and tidy and there were robust systems in place to reduce the risk of cross infection.

We saw areas of outstanding practice including:

Summary of findings

- A member of the practice staff carried out the role of carers coordinator. They made annual contact with every carer, personally, on the practice register to ensure they were receiving the care and support they required and updated the carers register based on their contact.
- The practice had completed over 300 coordinated care records for patients with most complex health needs. These had been securely transferred to the out of hours service to support patient care when the practice was closed.
- The practice manager met all newly registered patients and during this meeting they advised patients how to use the appointments system. We saw that 47% of patients were signed up to use the online appointment booking facility and many did so.
- One of the GPs had special interest and expertise in dermatology. There were fewer referrals to hospital dermatology departments compared to other practices because this GP was able to provide appropriate care and treatment at the practice for many dermatological conditions patients presented with.
- Five GPs held additional qualifications in obstetrics and gynaecology. This meant they could support the care and treatment of women presenting with gynaecological conditions and the referral rate to hospital gynaecology departments was lower than other practices.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. 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 patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice used the experience of GPs with special interests and expertise to treat patients with dermatological and gynaecological conditions at the practice This reduced the need for patients with these conditions to attend hospital departments. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff regularly worked with multidisciplinary teams and also worked closely with staff at the care homes where they provided general medical services.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. One hundred and seven patients took the time to complete CQC comment cards and 96% of these were wholly positive about the care patients received. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints and subsequent investigations was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a patient centred ethos and strategy. Staff were clear about their responsibilities in relation to delivering the best quality service possible in a timely manner. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient reference group (PRG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The most recent nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and longer appointments for those with enhanced needs.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. One GP had additional expertise in dermatology and we noted that this GP received referrals from colleagues of patients with dermatology conditions. The practice referred fewer patients with dermatological conditions to hospital than other practices in the area. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. The reviews for patients with more than one long term condition were co-ordinated to reduce the need to attend the practice for multiple reviews. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who were subject to child protection plans. Childhood immunisation rates were exceeding the national 90% target and compared favourably with the CCG. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the

Summary of findings

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Five of the GPs held additional qualifications in obstetrics and gynaecology. We noted that the practice referral rate to hospital gynaecology departments was lower than other practices in the area. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability. It had carried out annual health checks for patients with a learning disability and all seven patients who were eligible received their review in the last year. Longer appointments were available for all patients in this group. The practice had approximately 250 patients registered who lived in care homes. Many of these patients were in younger age groups and had acquired brain injury or a physical disability all had a care plan. The carers on the practice register were personally contacted annually to assess their needs and ensure they were met.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. There was a lead GP for mental health issues and the practice had care plans in place for 98% of patients on the mental health register.

Summary of findings

What people who use the service say

The results from the national patient survey undertaken in 2014 and completed by 112 patients showed a high level of satisfaction with the services provided by The Hall Practice. All 112 patients said they had trust and confidence in the last GP they saw and 99% expressed a similar level of trust and confidence in the practice nurses. Patients were generally happy with access to appointments. Ninety eight per cent of patients said their last appointment was convenient and 94% described their experience of making an appointment as good or very good. The respondents were also positive about the care and treatment they received with 96% saying the GPs gave them enough time and 95% saying the GPs were good at listening to them. Similar levels of satisfaction were reported in the last patient survey the practice carried out in 2014.

We received 107 completed CQC comment cards. These had been filled out by patients who attended the practice in the two weeks prior to our inspection. One hundred and two of the comment cards we received were positive. Many of the patients described the services they received as excellent and a majority complemented the practice on providing personalised care and continuity of care by offering all patients a named GP. The comment cards reflected a similar level of satisfaction with access to appointments and a number of patients told us how easy it was to get an appointment on the same day if they were in need of urgent medical advice or treatment.

We spoke with ten patients on the day of the inspection. Again we received positive feedback from all ten patients.

Areas for improvement

Outstanding practice

- A member of the practice staff carried out the role of carers coordinator. They made annual contact with every carer, personally, on the practice register to ensure they were receiving the care and support they required and updated the carers register based on their contact.
- The practice had completed over 300 coordinated care records for patients with most complex health needs. These had been securely transferred to the out of hours service to support patient care when the practice was closed.
- The practice manager met all newly registered patients and during this meeting they advised patients how to use the appointments system. We saw that 47% of patients were signed up to use the online appointment booking facility and many did so.
- One of the GPs had special interest and expertise in dermatology. There were fewer referrals to hospital dermatology departments compared to other practices because this GP was able to provide appropriate care and treatment at the practice for many dermatological conditions patients presented with.
- Five GPs held additional qualifications in obstetrics and gynaecology. This meant they could support the care and treatment of women presenting with gynaecological conditions and the referral rate to hospital gynaecology departments was lower than other practices.

The Hall Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services, they are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to The Hall Practice

The Hall Practice is located in a purpose built health centre which is shared with another GP practice. Over recent years the practice registered population has increased and the practice was planning to move to alternative premises to obtain additional space in which to provide care and treatment to its patients.

There are three GP partners at the practice and four salaried GPs. Three GPs are male and four female. The practice serves a patient population of approximately 9,500. The practice employs three practice nurses. The practice manager is supported by a team of administrative and reception staff. Some staff were jointly employed with the GP practice that shared the health centre. Services are provided via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

The practice population of patients aged over 45 is higher than average and there are fewer than average patients registered between the ages of 20 and 44.

The Hall Practice is accredited to provide training for qualified doctors who are preparing to become GPs. The practice received a visit for the accrediting body in 2014 and is approved to continue as a training practice.

The practice had been inspected in 2013. However, this was the first inspection under the new CQC comprehensive inspection approach and was undertaken to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Services are provided from:

The Hall Practice

Hampden Road

Chalfont St. Peter

Gerrards Cross

Buckinghamshire

SL9 9SA

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided via NHS 111. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the patient website.

Why we carried out this inspection

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

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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 been inspected in 2013 when provider ratings did not apply. 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

Prior to the inspection we contacted the Chiltern Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by The Hall Practice. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 2 April 2015. We spoke with 10 patients, four GPs, a GP in training and six staff. We reviewed 107 CQC comment cards that had been completed in the two weeks prior to our inspection. As part of the inspection we met with the practice manager and looked at the management records, policies and procedures.

The Hall Practice registered population has a larger number of patients aged over 45 and a lower number aged 20 to 44 than the national average. Approximately 250 of the practice patients reside in nursing and care homes which is significantly higher than neighbouring practices. The practice is located in an area of low income deprivation.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example when a travel vaccine had been administered which was not required, this was reported and logged appropriately. The practice also discussed all new diagnoses of cancer at weekly clinical meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last year. This showed the practice had managed these consistently and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the practice record of significant events that had occurred during the last year. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held twice a year to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, told us they would alert the practice manager about any issue that required consideration at the meetings and they felt encouraged to do so.

Staff reported incidents to the practice manager who completed incident report forms to be considered by the GPs. We reviewed the incident summaries for the last 12 months and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of an incident when a medicine was prescribed on a private prescription. The practice introduced a consistent policy for prescribing non-essential medicines. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice nurses and the GPs. Nursing staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, the recall of a specific type of pad used on defibrillators. When action had been taken or the alert had been identified as not relevant to the practice a record was kept by the nurses and a copy returned to the practice manager.

National alerts relating to safety of medicines were dealt with by the GPs. Action was monitored by the CCG medicines advisor and audits were repeated to ensure medicines withdrawn from use or dosage changes had been actioned.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies. Contact details were easily accessible.

The practice had appointed a GP as lead in safeguarding vulnerable adults and children. They had been trained and we reviewed their training record which showed they were trained to level three (the highest level) for safeguarding children to enable them to fulfil this role. All staff we spoke with were aware who these lead was and who to speak with 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 to make staff aware of any relevant issues when patients attended appointments. For example carers and patients with hearing aids who required the hearing loop to assist with communication.

There was a chaperone policy, which was clearly visible on the main noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. Administration staff would act as a chaperone if nursing staff were not available. These

staff had also undertaken training, completed a criminal records check, and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines that were kept 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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. There were records of the fridge temperatures being monitored on a daily basis and each medicine fridge had a battery operated backup thermometer to measure the temperature should there be a power failure.

Processes were in place to check medicines were within their expiry date and suitable for use. We checked 15 medicines from three different medicine fridges. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We noted that the practice met regularly with the CCG prescribing advisor and minutes of the weekly practice meetings showed prescribing was regularly discussed. This included reviewing the patterns of prescribing antibiotics, sedatives and anti-psychotic prescribing within the practice. The practice was striving to meet the local prescribing targets but achievement was affected by the large number of registered patients living in care homes. This was due to many of these patients having long term and complex health problems which required these types of medicine.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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 and kept securely at all times.

Cleanliness and 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 training about infection control specific to their role. We saw evidence that the lead had carried out audits for each of the last two years and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff wore aprons and gloves when assisting the GP who undertook minor surgical procedures. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had 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. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

There were records confirming servicing of other equipment relevant to the safety of delivering services from the premises. For example, the fire alarm system and firefighting equipment had been serviced as had the automated entry doors.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

There was a system in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Reception staff were jointly appointed with another GP practice that shared the premises. We saw that staff from either practice team covered reception when it became necessary. A rota system in place for all the different staffing groups to ensure that enough staff were 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. We noted that the practice recruited locum staff to cover long term absences. For example, when covering maternity leave. This applied to most staff roles. 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 keep patients safe.

Monitoring safety and 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Staff we spoke with told us that if they found a piece of equipment was not working or they had a concern about the environment they reported it immediately to the practice manager. Repairs and replacements were organised promptly to avoid risk to patients from unsafe equipment. For example a replacement medicines fridge had been purchased to replace a faulty fridge.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was 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, drugs overdose and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Disposable equipment needed to deal with medical emergencies, for example oxygen face masks, was also kept. We checked this equipment and also found it to be in good order and within expiry dates.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. 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 the company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Fire training updates were available via the online training package and there was an expectation that all staff would complete this training. The fire alarm system was tested regularly.

Outstanding ☆

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where clinical guidelines and local priorities were discussed. GPs led the discussions on specific clinical topics arising from their interests or lead roles. Copies of new guidance and the minutes of discussions were available to all via a file on the practice computer system. The staff we spoke with and the evidence we reviewed confirmed that the practice ensured guidelines were employed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with current best practice guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, mental health and dermatology. Practice nurses supported work with patients with long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example, advice and second opinion was sought from the GP with expertise in dermatology for patients who presented with skin conditions. Data showed us that the practice had a low referral rate to the hospital dermatology department as a consequence. The practice nurses we spoke with told us they practiced in line with current guidelines and took responsibility for care and support of patients with long term conditions in line with their levels of training and expertise. They told us that their roles in caring for this group of patients had expanded over recent years as they gained further training and experience.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. For example, referrals to dermatology and gynaecology were 20% below the local average because the practice GPs specialised in seeing patients with these conditions. For some patients this meant they were able to avoid the trip to hospital outpatient departments. We noted that local protocols for referral were available to all GPs via a folder on the practice computer system. All GPs we spoke with used national standards for the referral of patients with suspected cancers who needed to be seen within two weeks. There was a system to follow up these referrals.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice had a learning culture with a deep understanding of clinical audit and the impact on driving improvement. The practice manager showed us a set of files containing clinical audits completed during the last five years. This showed the practice had a commitment to reviewing clinical performance and had an active clinical audit programme. We reviewed a sample of ten of these audits five of which were two cycle audits. One audit had been repeated three times. This related to prescribing a medicine to reduce the risk of side effects of taking aspirin and other similar medicines. We noted that the first audit cycle showed 13 patients who had either not been assessed as needing the additional medicine or had not been prescribed it. The GPs had taken action to ensure the extra medicine was prescribed when required and by the third audit cycle only five patients had not been assessed. Other examples included audits to confirm that the GP who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. We noted that the practice shared the outcomes of prescribing audits with the locality group of the CCG.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of

preventative measures). For example, we saw an audit regarding the prescribing for and care of patients with atrial fibrillation (abnormal heart rhythm). Following the audit, the GPs were reminded of the best practice for caring for this group of patients. The second audit cycle showed an improvement in prescribing of blood thinning medicine for this group with 94% prescribed the medicine compared to 84% in the first year.

Records were maintained showing how the practice had evaluated the outcomes of audits and documented the success of any changes. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year. Practice nurses also used audit to review performance. The audit of success rates for taking cervical cytology smears showed only three unsuccessful smears in the last audit cycle. This equated to only 0.5% of all smears taken.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The data for the practice in 2013/14 had been affected by the change in computer system and the practice recognised that some interventions had not been appropriately transferred to the new computer system. We looked at the most up-to-date QOF data that had been produced two days before our inspection. This showed the practice had improved clinical performance from approximately 82% of targets achieved to 96% of targets achieved. The new data also showed the practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. One of the GPs had a special interest in end of life care. Lessons learnt from the care delivered to patients at the end of life were reviewed in a similar manner to significant events. For example one review resulted in the practice writing to local care homes asking them to inform the practice immediately if a patient receiving end of life care was admitted.

A member of practice staff was responsible for maintaining the register of carers and checking that carers received the support and care they required. Each patient on the carers register received a phone call once a year to ascertain their care needs and whether their circumstances had changed. If the contact resulted in identifying a shortfall in care provided the patient's GP was alerted to follow up the care needs. Patients we spoke with who were carers commented on the excellent support they received from the practice.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. We looked at one example of this benchmarking which showed the practice was in the top seven in the CCG for diagnosis of dementia.

Effective staffing

Practice staffing included GPs, practice nurses, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. For example, five held additional diplomas in obstetrics and gynaecology and one had an additional qualification in end of life care. One of the GPs had special interests in both minor surgery and dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

When GPs were appointed to the practice they were allocated regular supervision time with an experienced GP. Initially they met with the experienced GP once a week. The frequency of these support and supervisory sessions reduced over three months until the new GP had become

confident in the practice protocols and procedures. Some of the patients we spoke with and those who completed comment cards referred to new GPs being well trained in practice routines and procedures.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the nurses attended annual cytology updates to enable them to train GPs and other nurses in up-to-date techniques in cervical cytology smear taking. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and seeing patients with long-term conditions such as asthma, COPD and diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw 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 identified within the last year of any results or discharge summaries that were not followed up appropriately.

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

The practice held multidisciplinary team meetings every month to discuss the needs of patients with complex medical conditions, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in the minutes of the meetings. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We saw minutes of a practice meeting that tasked the introduction of formalised meetings with health visitors to discuss children at risk and any safeguarding matters. This would replace the regular but informal contact with health visitors.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice took part in the Buckinghamshire coordinated care record project and had uploaded 300 care plans to the out of hours provider. This meant that the out of hours service had access to the plans for those patients with the most complex care needs. Electronic systems were also in place for making referrals, and the practice made 85% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational during 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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. We saw evidence that an audit had been carried

out to assess whether all medicines prescribed for patients with long term conditions had been linked on the computer system to the condition and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and practice nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. A GP gave us an example of how they had discussed making a do not resuscitate order with the patient and their relatives.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. All patients living in care homes also had care plans and these were reviewed regularly. We saw evidence of this in patient records. GPs and practice nurses we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All GPs and nurses demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and fitting of contraceptive devices written consent was obtained. The GP who undertook minor surgery conducted an audit and found written consent was obtained for all procedures.

Health promotion and prevention

The practice met with the CCG to discuss the implications and share information about the needs of the practice population. Minutes of the locality meeting showed one of the GPs represented the practice. We also saw minutes of practice meetings at which local health priorities were discussed. For example, increasing the early diagnosis of dementia. The minutes showed the practice had an action plan to increase early diagnosis of this condition.

The practice provided a wide range of health promotion material in leaflets held in the entrance lobby. Some of the patients we spoke with commented on how useful these were and that they had taken information on an opportunistic basis. Patients were also able to take their own blood pressure and pass the results on to their GP or the nurse they were seeing. The GPs and nurses followed up on any indication of high blood pressure and there were 24 hour blood pressure monitors available for patients to take away. Recording blood pressure over 24 hours enabled GPs to make a more robust judgement on whether the patient required advice or treatment to maintain healthy blood pressure levels.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all of these patients were offered an annual physical health check. Records showed all seven eligible patients in this group had received their health check in the past year. The practice had also identified the smoking status of 84% of patients over the age of 16 and actively offered smoking cessation clinics to these patients. However, the latest data available to the CQC showed that only 64% of patients identified as smokers had been offered smoking cessation advice. This was lower than the CCG average. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. The practice was able to refer patients for exercise programmes at the local gym and also to refer to weight management groups and the local dietician. A care plan was developed for patients identified as requiring end of life care and this was coordinated with local health professionals such as the palliative care nurses.

The practice's performance for cervical smear uptake was just below the national 80% target. However, this was comparable or better than others in the CCG area. There was a system to remind patients who did not attend for cervical smears. There was also a named nurse responsible for following up patients who did not attend screening. The practice took part in the national programmes for

Outstanding ☆

Are services effective?

(for example, treatment is effective)

chlamydia, mammography and bowel cancer screening. Information stressing the importance of bowel screening was displayed on the information screen in the patient waiting room.

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 childhood immunisations was approximately 95% and was above average for the CCG. Again there was a clear policy for following up non-attenders by the practice nurse responsible for childhood immunisations. Flu immunisations were offered to all patients over the age of 65 and to those with long term conditions. The practice performance in administering flu immunisations compared well against the rest of the CCG. For example, in 2013/14 81% of patients who had a stroke received their flu immunisation. This was 3% above the national average and 1.5% better than the CCG average.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from 2014. This survey was completed by 121 patients. A survey of 348 patients undertaken by the practice's patient participation group (PPG) in 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was rated highly in satisfaction scores on consultations with doctors and nurses with 95% of practice respondents saying the GP was good at listening to them and 96% saying the GP gave them enough time. Patient feedback was consistently positive and was generally better than other practices in the CCG.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 107 completed cards and 96% were 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. Many patients commented on the benefits of having a named GP to provide them with continuity of care. Patients were also positive about the practice operating a named secretary service for each GP and they commented upon the benefits this gave them in building up a rapport with staff. Comment cards and discussions with staff showed the practice had a patient centred culture and personalised care was at the centre of practice activities. Five comments were less positive but there were no common themes to these. We also spoke with ten 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.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice secretaries booked appointments for patients with the patient's named GP. The secretaries were located on the first floor away from the reception desk. Reception staff directed incoming phone calls from patients by checking the patient's date of birth and passing the call to the relevant GP's secretary. Patients wishing to discuss aspects of their care were seen by the relevant secretary away from the reception area so that conversations could not be overheard by other patients in the waiting room. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Survey results, comments received on CQC comment cards and our discussions with patients on the day showed that patients did not have any concerns about their confidentiality being maintained.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 95% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Patients taking part in this survey gave similar ratings for the practice nurses when asked these questions. These results were at or above average compared to other practices in the CCG. Many of the 107 patients who completed CQC comment cards offered positive views on the explanations of treatment they received from GPs and felt involved in their treatment decisions. Some patients described the treatment options they had been given and that they were able to make the decision on which option to take. Nursing staff we spoke with gave us examples of providing written materials to support decision making and giving the patient time to take written information away before they reached a decision. There was evidence that patients were partners in decision making about the care and treatment they received.

Data showed us that all 250 patients living in care homes registered with the practice had a care plan. Ninety eight

Are services caring?

per cent of patients with mental health problems had care plans in place compared to the 90% CCG average. Care plans were agreed with patients and were reviewed annually or more frequently if required.

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. Patients also told us personally and on the comment cards that when a decision had been made to refer them to hospital or another service they understood why and the referral was dealt with swiftly and efficiently.

Patient/carer support to cope emotionally with care and treatment

GPs and nurses were aware of local groups that offered support to patients requiring emotional support. We were given examples of patients who had suffered a bereavement being referred to these groups. GPs and nurses told us how they allocated additional time to support patients who had suffered bereavement. Patients and GPs we spoke with told us the knowledge of each patient's circumstances afforded by the named GP system meant that support to bereaved patients was tailored to their circumstances. We were given examples of this by both staff and patients. When necessary follow up appointments were made to offer emotional support to patients who did not require any physical treatment.

Patients we spoke with told us they received support and advice in both understanding and coming to terms with a diagnosis of a long term condition. Nurses we spoke with told us how they spent additional time with patients who had recently been diagnosed with long term conditions to ensure the patient understood both the nature of their condition and the treatment and lifestyle regimes they would need to follow.

Notices in the patient waiting room and information on the patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they understood the various avenues of support available to them.

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 in the way services were delivered. For example, named GPs visited local care homes on a weekly rota.

The practice engaged with NHS England Area Team and Clinical Commissioning Group (CCG) and we saw that the plans to move into an adjacent premises to provide more spacious treatment facilities had been discussed with both organisations. The practice took part in local initiatives such as improving diabetic care and increasing the early diagnosis of dementia.

The practice had completed annual health checks for all patients with a learning disability. We were given an example of the practice sourcing a specific piece of equipment for a patient with a learning disability. The practice had not had to provide similar equipment before and had to research the availability. We heard that the patient had received the equipment within two hours of the need being identified and the patient's GP had visited them at home to ensure they were safe and receiving the urgent medical care they needed.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example more prominent signage and staff wearing name badges had been implemented in response to feedback.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, those with a learning disability, carers and patients living in care homes.

Consulting and treatment rooms were located on the ground floor. Automated entry and exit doors were fitted to the premises to assist patients with mobility problems. All rooms used for care and treatment of patients were located off of the main waiting room and we saw that the practice had made arrangements to assist patients who used mobility scooters by the provision of wheelchairs in which these patients were transferred to the consulting and treatment rooms. The practice recognised that the space available to them was no longer sufficient to offer services to the large number of patients registered and that access to some of the rooms was difficult for patients with mobility problems. Plans were well advanced to move in to the building next door and final approval and funding of this project was awaited.

A hearing loop was available to assist patients who used hearing aids. Written information was available in large print upon request for patients with a visual impairment.

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

The practice provided equality and diversity training through e-learning. We reviewed the staff training records and saw that all staff who had been in post for more than three months had completed equality and diversity training.

The practice had very few patients registered whose first language was not English. However, a translation service was available. Staff told us this service had rarely been accessed.

Access to the service

Appointments were available from 7:30 am to 5.30 pm on three days of the week, from 8am on Tuesday and from 7am on a Wednesday. The practice was open until 6pm and did not close during the lunch time period. The last bookable appointment each day was at 5.30pm. Patients who called later in the afternoon with an urgent need for an appointment were seen after 5.30pm. A GP was available to support patients between 6pm and 6.30pm each weekday until the out of hours service commenced. The practice had sought feedback from patients and found that early morning appointments were preferred to evening appointments.

A range of pre-booked and urgent appointments were available each week day and all patients had a named GP to support continuity of care. When the patient's named GP was unavailable the patient was able to see any GP. Telephone consultations were available for patients who found it difficult to attend the practice. For example if they had difficulty leaving the house or due to their work

Good

Are services responsive to people's needs?

(for example, to feedback?)

commitments. We reviewed the availability of appointments and saw that a range of appointments were available to be booked for the next working day following our inspection.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice manager met all newly registered patients and during this meeting they advised patients how to use the appointments system. We saw that 47% of patients were signed up to use the online appointment booking facility and many did so.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Some of the patients we spoke with told us they had booked their appointments on the morning of our inspection and were seen within two hours.

The practice's extended opening hours on all five weekday mornings were useful to patients with work commitments. All the patients we spoke with and the feedback available via comment cards and surveys showed patients were satisfied with the availability of appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for coordinating investigations into and responding to complaints. A patient's named GP was involved in the complaint investigation process.

We saw that information was available to help patients understand the complaints system. There was a notice on the noticeboard and the complaints process was set out in both the patient leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Two patients we spoke with had used the complaints system and had their complaints resolved. Staff we spoke with were knowledgeable about the complaints system and described how they would support patients to make a complaint. We saw that a suggestions box was available for patients who wished to remain anonymous to post any complaints and concerns.

We looked at the six complaints received in the last 12 months and found all had been dealt with in a timely manner and apologies had been given when something had gone wrong. The records showed that full investigations had been undertaken and detailed explanations of findings recorded and shared with the patient. The practice reviewed complaints annually to detect themes or trends. Staff confirmed that if a complaint related to their area of work it was shared with them and lessons learnt from the complaint were followed up.

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 mission statement, a statement of purpose and a patient charter. These were underpinned by a core ethos of delivering the best quality of care to patients in a timely manner. The mission statement was built in to the practice business plan and it included providing an appropriate and rewarding experience for patients whenever they needed support from the practice.

We spoke with six members of staff and they all knew and understood the values of the practice and knew what their responsibilities were in relation to these. Patients we spoke with and other sources of patient feedback reflected patients satisfaction that the practice was achieving their mission statement.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These policies were available to staff in a shared computer file or in a policies manual. The staff we spoke with told us they knew where to find the policies manual and would refer to it if they needed to. We looked at 10 of these policies and procedures and they were reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a named partner was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its 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 monthly team meetings and action was identified to maintain or improve outcomes. We saw data that showed 96% of all clinical targets had been achieved in 2014/15.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the outcomes of minor surgical procedures, quality of cervical smear taking and reducing the risks of cross infection were subject to annual audit.

The practice health and safety policy was underpinned by a range of risk assessments that had been carried out where risks were identified. For example, there were risk assessments for manual handling, control of substances hazardous to health (COSHH) and access and egress to the practice.

There was an information governance policy and staff were trained, or due to be trained, in information governance processes. The practice had completed the national audit tool to confirm it was using, storing and securely keeping patient data appropriately.

The practice held weekly meetings at which governance issues were regularly discussed. We looked at two sets of recent minutes and found that performance and quality had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. 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, the induction policy, maternity/paternity policy and management of sickness which were in place to support staff. We saw the practice had a staff handbook which was available both electronically and in a central file and was available to all staff. There was a separate policy on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The practice business plan identified both opportunities and challenges the practice needed to address. For example, there was reference in the plan to the potential for two salaried GPs to become partners and to the challenge of providing sufficient space to deliver services to an increasing patient population.

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

The practice had gathered feedback from patients through a survey of the members of the virtual patient reference group. The last survey was in 2014 and was sent to 348 patients. We looked at the action plan from the last survey and saw that patients requested better definition of the

Are services well-led?

Good

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

practice from the other GP practice sharing the same health centre. Consequently better signage had been put in place and staff wore name badges to distinguish them from the staff of the other practice located on site.

The practice had an active virtual patient participation group (PPG) which had steadily increased in size. The PPG included representatives from all population groups because all patients were invited to join when they registered with the practice. The action plan form the last PPG survey was available on the practice website. Patients were also able to offer feedback via a suggestions box in the main waiting area.

The practice gathered feedback from staff through staff meetings, day to day discussions and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues the GPs and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place. There was a staff training plan in place and staff were encouraged to undertake training relevant to their roles via an online learning package. Staff we spoke with told us they were able to undertake relevant training courses funded by the practice and followed the practice training policy to apply for such training.

The practice was a GP training practice providing training for qualified doctors who had decided to become GPs. These prospective GPs were supported by one of the senior GPs who was a qualified trainer. We saw that some of the GP trainees who had completed their year at the practice had opted to complete an additional six months training and stayed on for this.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. For example when a travel vaccine had been administered which was not prescribed this was investigated and action was taken to reduce the risk of reoccurrence.