The Over-Wyre Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of The Over Wyre Medical Centre.

We carried out a comprehensive inspection on 11 December 2014. We spoke with patients, members of the patient participation group and staff, including the management team.

The practice was rated as good overall. A safe, caring, effective, responsive and well-led service was provided that met the needs of the population it served.

Our key findings were as follows:

- All staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were maximised to support improvement.
- The practice was proactive in using methods to improve patient outcomes. Best practice guidelines were referenced and used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation.
- Feedback from patients was positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to provide kind and compassionate care.
- The practice reviewed the needs of their local population and had initiated positive service improvements for patients that were over and above their contractual obligations. They implemented suggestions for improvements as a consequence of feedback from the patient participation group.
- The practice had a clear vision which had quality and safety as top priorities. High standards were promoted and owned by all practice staff with evidence of team working across all roles. There was a strong

Summary of findings

governance structure in place. The leadership culture was open and transparent. The practice had a clear understanding and commitment to the needs of staff. We found high levels of staff satisfaction.

We saw several areas of outstanding practice including:

- The practice had completed an extensive programme of clinical audits over the last 12 months. Audits reviewed were comprehensive and had resulted in changes to improve patient outcomes. We saw an example of an audit where the practice had obtained and taken into account patient feedback in evaluation of the results.
- Patients were able to view a copy of their personal NHS summary care record through a secure on line facility on the practice website.
- The practice offered a total of 23 enhanced services to improve patient outcomes. A good skill mix amongst the staff enabled the practice to respond to changing priorities and demands. The practice manager regularly reviewed the non-clinical staff resource available to ensure it was used to optimum effect in delivering service.
- There were robust and comprehensive systems in place to manage and monitor risks to patients, staff and visitors. This included risks to the building, environment, medicines management, staffing equipment and a range of emergencies that might affect operation of the practice.
- We were given eight examples of the practice responding to feedback from their Patient Participation Group and taking action to improve the service including amendments to the appointment system.
- There were six nursing homes in the locality which were served by the practice. Each home had an allocated GP who carried out routine ward rounds at their respective homes on a weekly or fortnightly basis as required.

In addition the provider should:

- Ensure all changes to patients' medicines when delegated are checked by the GP for accuracy.
- Ensure medicines awaiting collection are locked in the dispensary when the surgery is closed.

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, report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risk management was comprehensive and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. The practice had links to neighbouring practices to share best practice. Patients' 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. Staff received training appropriate to their roles and further training needs had been identified and planned. The practice had appraisals and personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect. They were involved in planning for their care and treatment. We observed a patient centred culture and found strong evidence staff were motivated and inspired to offer kind and compassionate care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP or GP of choice, continuity of care and urgent same day appointments as required. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Summary of findings

Are services well-led?

Outstanding 

The practice is rated as outstanding for well-led. The practice had a clear vision, which had quality and safety as it's top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements were proactively reviewed. The practice was mindful of the need for succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients through surveys and the Patient Participation Group and acted upon it where possible.

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. Nationally reported data showed that 32% of the patient population were aged 65 or above in comparison with a national average of 16.5%. The practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, avoidance of unplanned admissions to hospital, timely diagnosis and support for people with dementia, and a shingles vaccination programme for those aged 70 and above. The practice was responsive to the needs of older people including offering home visits, telephone consultations and routine ward rounds for those living in care or nursing homes.

People with long term conditions

Outstanding

The practice is rated as outstanding for the population group of people with long-term conditions. There was a high prevalence of conditions such as cardiovascular disease, COPD and diabetes amongst the patient population. There were named GP leads for each area. Nursing staff had additional training and qualification which enabled them to focus upon specific chronic conditions and lead in management of them through a comprehensive schedule of clinics. All these patients had structured annual reviews to check their health and medication needs were being met. For those with the most complex needs GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. When needed longer appointment times and home visits were available. Emergency processes were in place for patients in this group who had a sudden deterioration in health. The practice offered enhanced services to meet the needs of patients with long-term conditions such as avoidance of unplanned admissions to hospital through care planning and initiation of insulin for diabetics.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates for standard childhood vaccinations were relatively high. A range of enhanced services were available such as whooping cough in pregnant women, hepatitis B for new born babies, MMR vaccination for young

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people and contraception services. Appointments were available outside school hours and the premises were suitable for children and babies. We were provided with examples of joint working with midwives and health visitors. One of the nurses was specifically trained as a child chaperone. Children and young people were treated in an age appropriate way and recognised as individuals.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible. Patients were able to book appointments and request repeat prescriptions using online facilities and there were extended opening hours. A full range of health promotion and screening which reflects the needs for this age group was available and a number of enhanced services. For example, Meningitis C immunisation for new students.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example travellers and those with learning disabilities. Patients with learning disabilities were offered annual health checks. Longer appointment was booked and easy read health records had been produced to aid understanding. The practice had both named GP and nursing lead for learning disabilities.

The practice worked with multidisciplinary teams in the case management of vulnerable patients. Staff knew how to recognise the signs of abuse in vulnerable adults and children. Staffs were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The patient population had included a large group of travellers who had been registered at the practice but moved on several months ago. The practice had proactively engaged with the travellers, inviting representatives into the practice to welcome them to the service, manage their expectations of it and discuss how they could best work together.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

Summary of findings

Patients within this group received an annual physical health check. The practice worked with multidisciplinary teams in the case management of people experiencing poor mental health. The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia. Advance care planning was in place for this group. There were named GP leads for mental health, depression and dementia.

The practice provided a single point of access to counselling services for those with poor mental health. Counsellors and a child psychologist carried out clinics at the practice. The practice signposted patients to support groups, voluntary and community organisations. They were proactive in promoting the Big White Wall Service, a self-help counselling service for those with mental health issues.

Summary of findings

What people who use the service say

We received 25 completed comment cards which included feedback from male and female patients across a broad age range. Patients spoke positively about the practice, and the care and treatment they received. Their descriptions of staff included helpful, friendly, thorough and kind. Patients told us staff were understanding and they were treated with dignity, compassion and respect. They told us staff listened to them and took time to discuss and explain treatment options. Patients felt involved in planning their care and treatment.

Most patients expressed satisfaction about the ease with which they could get an appointment. One person commented that it could be difficult to make contact by telephone and two told us there could be some delay before a routine appointment was available.

Several patients commented on the environment. They told us it was always safe and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all changes to patients' medicines when delegated are checked by the GP for accuracy.
- Ensure medicines awaiting collection are locked in the dispensary when the surgery is closed.

Outstanding practice

- Nursing staff had additional training and qualifications which enabled them to focus upon specific chronic conditions and lead in the management of the condition. For example, two of the nurses were trained in insulin initiation.
- The practice had completed an extensive programme of clinical audits over the last 12 months. Audits reviewed were comprehensive and had resulted in changes to improve patient outcomes. We saw an example of where patient feedback had influenced the outcome of an audit.
- The practice participated in a neighbourhood system promoted by the local CCG. This enabled them to compare their performance with that of similar surgeries in the area and share learning with a view to improving outcomes.
- Patients were able to view a copy of their personal NHS summary care record through a secure on line facility on the practice website.
- The practice offered a total of 23 enhanced services to improve patient outcomes. An appropriate skill mix amongst the staff enabled the practice to respond to changing priorities and demands. The practice manager regularly reviewed the non-clinical staff resource available to ensure it was used to optimum effect in delivering service.
- There were robust and comprehensive systems in place to manage and monitor risks to patients, staff and visitors. This included risks to the building, environment, medicines management, staffing equipment and a range of emergencies that might affect operation of the practice.
- We were given eight examples of the practice responding to feedback from their Patient Participation Group and taking action to improve the service.
- Staff were well supported and valued. Staff knew and understood the practice vision and values and their responsibilities in relation to it. It was clear the team was fully committed to achieving them. It was also clear the practice had a dedicated and cohesive team of staff who had mutual respect for each other. The practice encouraged staff to share their ideas and take ownership of the service through appraisal and meetings, including brainstorming sessions. We found a willingness to invest in people and develop staff.

Summary of findings

- There were six nursing homes in the locality which were served by the practice. Each home had an allocated GP who carried out routine ward rounds at their respective homes on a weekly or fortnightly basis as required.

The Over-Wyre Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Over-Wyre Medical Centre

The Over Wyre Medical Centre was established in 1990. It is an amalgamation of a number of partnerships that previously existed in the Preesall area and serves all the Over Wyre population.

There are 11033 registered patients.

The Over Wyre Medical Centre is a dispensing practice. There is a branch surgery in nearby Hambleton. We did not visit the branch surgery on this occasion.

The patient population comprises significantly more over 55s than the national average. This is particularly true of the age group 65 to 74 years. There are significantly less under 45s than the national average, particularly those under 35 years. Information published by Public Health England rates the level of deprivation within the practice population group as eight on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice team comprises of seven GPs including three females, two nurse practitioners, nine nurses and two healthcare assistants. The practice manager is supported by a team of reception and administrative staff. The practice has a patient participation group.

Opening hours at the main site are 7.30am to 8.00pm on Mondays, and 7.30am to 6.30pm Tuesday to Friday. Surgeries are available mornings, afternoons and evenings. Hambleton branch surgery is open each weekday morning. The opening hours are varied but the core time is between 9.00am and 10.00am. When the practice is closed an out of hours service, Fylde Coast Medical Services, meets the care and treatment needs of patients.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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)

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew. We spoke with the Chair of the practice Patient Participation Group by telephone. The information reviewed did not highlight any risks across the five domain areas.

During our visit we spoke with GPs, members of the nursing team, the practice manager, reception and administrative staff. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards were made available at the surgery prior to inspection.

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, comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed documentation and clinical indicators, such as the child immunisation, cancer detection and cervical screening rates that showed the practice had a track record of safety and performance.

The practice manager was aware of their responsibilities to notify the Care Quality Commission about occurrences that would seriously reduce the practice's ability to provide care.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. The records kept of significant events that had occurred were made available to us. Events were comprehensively documented and analysed. Lessons learned were extracted and shared with staff through team meetings. We saw that changes in practice had been applied, for example, following an incident where there had been delay in delivery of a medication to a nursing home the practice had introduced a new protocol to minimise the risk of recurrence.

The practice maintained an incident book. We tracked an incident that had occurred when a member of staff had accidentally splashed the contents of an injection into their own eye. We saw records had been completed in a comprehensive and timely manner and appropriate action had been taken.

National patient safety and medicines alerts were reviewed by the practice manager and cascaded by email to staff appropriately. One of the GPs was nominated as safety alert lead and took responsibility for ensuring that any necessary changes were implemented.

Reliable safety systems and processes including safeguarding

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

Practice training records showed that all staff had received training in safeguarding adults and children to at least a minimum level appropriate for their role. One GP took responsibility as practice lead in relation to safeguarding. They, and several other members of staff had achieved training to a more advanced level three. Staff knew who they should speak with in the practice if they had a safeguarding concern.

Staff knew how to recognise the signs of abuse and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns. We saw that, using a recognised toolkit, the practice had completed an audit to verify their understanding.

The practice had comprehensive safeguarding policies and procedures for children and vulnerable adults. These were up to date and readily accessible to staff through the practice intranet. Staff knew how to contact relevant agencies in and out of hours. Contact details and guidance on the processes to be followed were readily accessible in the offices, consultation and treatment rooms.

There was a system to highlight vulnerable patients on the practice's electronic records and include information to make staff aware of any relevant issues when patients attended for appointments, for example, children subject to child protection plans.

The practice had a chaperone policy in place. Notices were displayed in the waiting area advising patients they could request a chaperone during their consultation if they wished. It was practice policy that only members of clinical staff would act as chaperones when a request was made.

Patient's individual records were managed in a way that helped ensure safety. Records were kept on an electronic system which collated all communications about the patient, including scanned copies of communication from hospitals.

Medicines management

We found the practice had good arrangements in place for the management of medicines. There were protocols for medicines management that were followed in practice and covered all required areas. Protocols were recently updated and staff were familiar with them.

We checked vaccines stored in the refrigerator and found they were stored securely. Maximum and minimum temperatures of the refrigerator were monitored. This

ensured the vaccines were fit for use. Vaccines were administered by practice nurses using directions that had been produced in line with legal requirements and national guidance. We saw copies of directions that were signed by the nurses who used them.

We saw a system in place for managing hospital letters. These were scanned and sent to the GP for review. We were told the GP would make some changes to patients' medicines records but sometimes the task of updating the records was delegated to the prescriptions clerk. There was no double checking system to ensure that these changes to medicines records were made correctly.

Medicines storage in the dispensary was secure. However, we saw that medicines awaiting collection were not secured in the locked dispensary when the surgery was shut. Processes were in place to check that medicines were within their expiry date and suitable for use. All the medicines we checked, except one, were within their expiry dates. The expired medicine was immediately removed. Prescriptions were checked and signed by GPs before medicines were dispensed and given to patients.

The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Staff who dispensed medicines were experienced in the task and received annual appraisals to check their competence. Dispensed medicines were double checked by Accredited Checking Technicians who were trained in the task. Systems were in place to monitor and manage medicines errors to reduce the risk of them happening again. This helped to ensure patients received their medicines correctly. The practice planned to introduce regular meetings between dispensary staff and the GP who takes the lead for the dispensary to review and improve the quality of medicines management.

The practice had established a service to deliver dispensed medicines to patients' homes. Arrangements were in place to ensure the safe delivery of medicines liable to misuse and those requiring immediate refrigeration on delivery.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Controlled drugs were recorded correctly and were stored in a controlled drugs cupboard. Access was restricted and the keys held securely. We checked two controlled drugs against records and the stocks were correct. There were arrangements in place for the destruction of controlled drugs. The practice had a system in place to monitor prescriptions for controlled drugs that were sent to community pharmacies for dispensing to prevent diversion or loss.

We saw processes in place for checking emergency medicines and medicines stored in GP bags to ensure no expired stock was kept. Blank prescription forms were handled in accordance with national guidance and were kept securely.

The practice received prescribing support from a Clinical Commissioning Group pharmacist. We saw that audits were done to improve the way medicines were managed. We saw evidence that the work resulted in the improvement of the quality of prescribing of antibiotics, anti-inflammatory medicines and sleeping tablets. National alerts regarding medicines safety were addressed and action plans put in place to promote patient safety.

The practice used the services of an external provider to carry out blood tests and to provide dosage advice to patients who were prescribed the blood thinning medicine called warfarin. The practice had introduced a system of notifying the provider when patients were prescribed antibiotics that could interact with warfarin and therefore might require closer monitoring. However, following blood tests the provider did not always make results promptly available to the practice. Whilst the practice updated patients' medical records immediately following receipt of the information, the delay in receipt meant that GPs may not be aware if patients were not within acceptable parameters.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice employed cleaners to attend on a daily basis. There were cleaning schedules in place and cleaning records were kept. Patients who commented on the environment told us they had no concerns about cleanliness or infection control.

All staff completed training on infection prevention and control as part of their induction. Thereafter they were required to follow a programme of refresher training utilising a package of e-learning the practice had purchased. Completion of training was monitored. An infection control policy and supporting procedures were available for staff to refer to. This provided guidance on

specific situations, for example, use of personal protective equipment, dealing with spillage of blood and responding to a needle stick injury. We saw there were adequate supplies of equipment available to staff to enable them to follow the protocols.

One of the nurse practitioners led on infection control. This role was relatively new. As part of their role they had responsibility for preparation and review of policy and protocols in this area. They were supported in their lead role by a named GP. They met regularly with the cleaners and with the infection prevention and control nurse (IPC) for the local authority area. The nurse practitioner told us that when they had first taken over the role they had arranged for the local authority IPC nurse to carry out an audit of the practice and branch practice to ensure standards were correct. They now intended to audit annually to ensure this remained the case.

Clinical staff were responsible for maintaining infection control measures within their own consultation and treatment rooms during the course of the day. The lead told us that as part of the appraisal process they checked that members of the nursing team were up to date in their knowledge and understanding of cleaning requirements.

Hand hygiene technique signage was displayed in staff and patient toilets, consultation and treatment rooms. Hand washing sinks with hand soap, hand gel and paper towel dispensers were available. We saw evidence that the lead carried out audits to verify that staff were following correct procedure.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Regular checks were carried out in line with policy to reduce the risk of infection to staff and patients.

The practice had systems in place for segregation of clinical and non-clinical waste. There were sharps bins in each treatment room which were not readily accessible to patients. An external contractor attended the practice on a regular basis to collect clinical waste and remove it off site for safe disposal.

Equipment

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 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, blood pressure monitors, electrocardiogram (ECG) machines and weighing scales.

As part of the appraisal process the IPC lead checked that nursing staff were up to date in their knowledge and understanding of equipment use.

Staffing and recruitment

Staff records we looked at were well organised. They 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. We saw evidence that criminal records checks were made via the Disclosure and Barring Service prior to employment of clinical staff. Staff deemed not to require a DBS check to fulfil their role had completed risk assessment documents within their files to support this decision. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure there were enough staff on duty to meet operational needs. There was also an arrangement whereby members of staff covered each other's annual leave. The practice had a stable staffing team with little turnover. Staff told us there were usually enough staff to maintain the smooth running of the practice and always enough staff on duty to ensure patients were kept safe. One GP was unavailable for work at the time of inspection and the other GPs were working additional hours to provide cover and maintain levels of service during this time.

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. These included regular checks of the building, the environment, medicines management, staffing, arrangements for dealing with emergencies and

Good

Are services safe?

equipment. The practice had a health and safety policy. One of the noticeboards in the staff area was dedicated to the display of health and safety information. There was a named health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that risks identified included personal security, cold weather, working at heights, control of substances hazardous to heath (COSHH) and locking the surgery at night.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had up to date training in basic life support. Emergency equipment was available including access to oxygen and an automated 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 it was checked regularly.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included medicines for the treatment of cardiac arrest, allergic reaction and low blood sugar.

The practice had a comprehensive business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice including flood, pandemic, fire and terrorism. We saw that risks associated with both service and staffing changes (both planned and unplanned) were included. Each was risk rated and mitigating actions recorded to manage and reduce risk. The document contained relevant contact details for staff to refer to including local area team and health service contacts, local tradesmen and suppliers. There was a communication cascade instruction to ensure messages were delivered to all staff in a timely and effective manner. Full details of all items of information technology (IT) and communication equipment within the practice had been logged and incorporated into the plan.

The practice completed a full fire risk assessment every two years, the last one having been carried out in September 2013. Records showed that staff were up to date with fire training and regular fire drills were undertaken.

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 and able to access guidelines from the National Institute of Health and Care Excellence (NICE) directly via their computers. 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.

GPs had special clinical areas of interest in which they lead the practice, for example, diabetes, cancer and asthma. Members of the nursing team also had special clinical areas of interest in which they held additional qualification enabling them to support the work of the GPs by focusing on the management of specific conditions. For example, two of the nurses had completed extra in-depth training on asthma and COPD and two were trained to start patients on insulin. Clinical staff we spoke with were very open about asking for and providing colleagues with support and advice. Nurses took responsibility for preparation and review of policy and protocols in their respective areas of interest and were supported by the named lead GP for that area in doing so. A formal programme of meetings provided a forum for clinicians to meet together regularly to share information and learning and ensure adherence to best practice and current guidelines was maintained.

Read coding was used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. These codes improve patient care by ensuring clinicians base their judgement on the best possible information available at any given time.

Referrals to secondary care were made in line with national standards. There were effective systems in place to ensure that all incoming post to the practice was coded, attached to the relevant patient's records and brought to the attention of the GP in a timely manner.

Management, monitoring and improving outcomes for people

Patients' comments demonstrated they were extremely satisfied with the care and treatment they received at the practice. Staff said they could openly share concerns about clinical performance.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles include data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collated was used by the practice to carry out clinical audits.

The practice had completed 22 audits over the last 12 months and a number of further audits were on-going. Examples of clinical audits completed included subjects such as fitting and removal of coils (IUCD), optimising medical therapy in angina, rheumatoid arthritis and methotrexate monitoring, and management of over active bladder syndrome. We were shown two of the audits completed including stroke prevention in atrial fibrillation. We saw that the audit was comprehensive and had resulted in changes to improve patient outcomes. The practice had invited 55 eligible patients to attend an integrated care clinic run at the practice by a local cardiologist and 24 had done so. As a result of the clinic nine patients were subsequently anti-coagulated.

The GPs told us that 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. We saw that an audit had been completed in relation to diagnosis and treatment of patients with lower urinary tract symptoms. Of the 53 patients who participated 26 had changes made to their medication as a result, including four for whom medication was stopped. The practice was supported by a Clinical Commissioning Group pharmacist whose role included constant audit of the practice's medicines management and conduct of reviews.

The practice also used the information they collected for the QOF and their performance against national screening to monitor outcomes for patients. The practice had a dedicated team of data staff whose role included ensuring high quality accurate data was collected and continually monitored and review to improve patient outcomes. The practice was a high performer against QOF clinical targets.

Good

Are services effective?

(for example, treatment is effective)

We saw the practice also completed audits of non-clinical aspects of the service. For example, an audit had been completed covering a multitude of areas from chronic disease management to patient access. Improvements that could be made to disabled access, premises and other areas had been identified and a practice quality improvement plan to address them created.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff told us how as a group they reflected upon the outcomes being achieved and areas where they could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

Regular checks were made to ensure that patients receiving repeat prescriptions had been reviewed by a GP. The data team checked that all routine health checks were completed for long-term conditions such as diabetes. At the start of each month the team searched the data base to identify patients due for recall for chronic disease management and sent each a letter offering an appointment. One of the nurses who lead on management of diabetes told us how they regularly audited patient data to identify any patients not meeting optimal control of their condition and address it. Staff were proactive in following up any non-attendance through letters and telephone calls.

The practice participated in a neighbourhood system promoted by the Clinical Commissioning Group. This enabled them to compare their performance with that of similar surgeries in the area and share learning with a view to improving outcomes. The practice had trialled approaches to medicines management and nursing home protocol which were now being rolled out across the neighbourhood.

Effective staffing

All the patients who provided feedback were complimentary about the staff. We observed staff who appeared competent, comfortable and knowledgeable about the role they undertook.

The practice had a formal induction process for any new staff joining the team. New members of staff completed an induction programme tailored to meet the requirements of their role.

All staff maintained a range of mandatory training including fire safety, basic life support, safeguarding of adults and children. The practice also provided access to additional role specific training for clinical and non-clinical staff. Systems were in place whereby the practice manager was able to monitor the completion of training by staff to ensure they remained up to date in their knowledge. Minutes of practice management meetings showed that the availability of additional forthcoming training events in the locality were a standing item on the agenda.

A good skill mix was noted amongst the GPs with some having additional qualification in areas such as psychiatry, contraception and diabetes. 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 every five years undertakes a fuller 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 appraisal which identified learning needs from which personal development plans were created. Staff interviews confirmed the practice was proactive in encouraging staff development by providing training, mentor support and funding for relevant courses. For example, one GP was acting as mentor to a nurse practitioner to support them in their studies for a masters degree.

The practice also participated in an apprenticeship scheme offering apprentices work training experience, for example, within the dispensary and administrative teams. It was clear from speaking with staff that the apprentices were highly valued as part of the team and we were told that previous apprentices had subsequently accepted permanent employment.

Working with colleagues and other services

All practice staff worked closely together to provide an effect service for patients.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from local hospitals including discharge summaries, and correspondence from the out of hours provider were received both electronically and by post. Staff understood their respective roles in reading, passing on, and acting upon any issues arising from them

in a timely manner. The practice operated a buddy system amongst the GPs to ensure necessary actions were addressed promptly should a member of the team be absent.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example, those with end of life care needs. They worked in collaboration with the local hospital to meet the needs of patients prescribed warfarin. For example, the hospital warfarin clinic carried out blood testing in a local church hall to establish an appropriate dosage which the practice then prescribed and dispensed. If a patient was subsequently prescribed medication that may interact with warfarin systems were in place to promptly alert the warfarin service of this. The practice served as a single point of access for those with mental health needs. Counsellors, including a child psychologist, attended the practice to provide services from the site. Nursing staff told us they had good working relationships with local community and district nurses liaising regularly to ensure that the chronic disease management needs of housebound patients were met. The practice actively participated in a neighbourhood system promoted by the Clinical Commissioning Group whereby they worked collaboratively with other local surgeries.

There were six nursing homes in the locality which were served by the practice. Each home had an allocated GP who carried out routine ward rounds at their respective homes on a weekly or fortnightly basis as required.

The practice engaged proactively with other services to extend and improve the care and treatment options available to meet the needs of their patient population. They offered a number of enhanced services including extended hours access, referral support and pathway enhancement, initiation of insulin in general practice, flu and shingles vaccination programmes and avoidance of unplanned admissions.

Information sharing

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

The practice held monthly management meetings and GPs met regularly with nursing staff. All clinical staff worked Wednesdays which enabled the practice to schedule clinical events at a time when all clinicians were available to attend. Non-clinical staff met together and each quarter the practice held a primary healthcare team meeting for all staff. Information about risks and significant events was shared openly and honestly. One GP attended Clinical Commissioning Group meetings and shared information from these with the staff. This kept staff up to date with current information about local enhanced services and requirements in the community.

There were electronic systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. The software enabled scanned paper communications, such as those from hospitals, to be saved in a patient's records for future reference. The electronic systems at the practice were well established and staff were trained and confident in their use. The practice had been early adopters of IT initiatives subsequently rolled out throughout the CCG. For example, they made an early investment in software that enabled staff to access to all practice policies and procedures electronically through any computer terminal. One of the GPs was trialling a system which would enable them to have direct access to a patient's electronic records during a home visit using a heavily encrypted laptop rather than rely on a paper based summary print out.

The practice supported the electronic NHS summary care record scheme for emergency patients. Under the scheme, with a patient's consent, a summary of their care record is provided to healthcare staff treating patients in an emergency or out of hours situation which enables them to have faster access to key clinical information.

The practice website included information for patients about services available at the practice, signposting to other healthcare providers and support groups, and latest news. Similar information was displayed on site. Each month the practice manager included an article in a local community information booklet, Over Wyre Focus. We saw that recent articles had included promotion of the flu

Good

Are services effective?

(for example, treatment is effective)

vaccination campaign and an explanation of care planning and its purpose. The practice had recently engaged with the children at a local high school by initiating an art competition. GPs had attended the school to judge the competition and artwork from it was displayed in the waiting area of the practice.

Consent to care and treatment

The practice had a comprehensive policy on consent and decision making for patients who attended the practice. The policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate. A number of templates had been produced for completion in circumstances where written consent from a patient was required, for example for minor surgery.

Patients with learning disabilities and dementia were supported to make decisions through use of care plans which they were involved in agreeing. GPs and nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation. The programme of e-learning available to staff included modules on mental capacity, learning disability and dementia awareness. The practice had identified where this training was relevant to a staff member's role and there was an expectation that it would be completed. The training records we looked at showed that some members of staff had already done so, for others remained outstanding. Minutes of practice meetings showed the practice manager had oversight of the training records and was monitoring the position.

Health promotion and prevention

Each new patient registering with the practice was offered a health check with a member of the nursing team. This included discussions about their environment, family life, mental health, physical wellbeing as well as checked on blood pressure, smoking, diet, alcohol and drug dependency. Any health concerns highlighted were promptly referred to a GP and followed up. The practice also offered NHS health checks to all its patients aged 40-75 years.

A full range of immunisations for children, travel vaccines and flu vaccines was offered in line with current national guidance. The practice additionally participated in a number of enhanced service schemes aimed at health promotion and prevention. These included: Meningitis C for new students; Hepatitis B for new born babies; shingles vaccination for over 70s; pertussis (whooping cough) vaccination for pregnant women; and measles, mumps and rubella vaccination for those aged 16 and over.

Systems were in place to identify patients who needed additional support and the practice was proactive in offering help. For example, they maintained a register of all patients with a learning disability who were offered an annual health check. We saw that easy read health records had been produced to assist patients with the annual review process. Double length appointments were made for these reviews to allow for extra time for explanation. Staff were proactive in offering memory assessments and screen for dementia. A further enhanced initiative to streamline the existing process was shortly to be introduced. Named GPs lead in areas such as dementia, learning disability, mental health and depression. The practice worked collaboratively with counsellors and child psychologists to provide a single point of access to such services for their patients. They were also proactive in promoting the Big White Wall Service, a self-help counselling service for those with mental health issues.

There was a clear policy for following up on non-attenders.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patient feedback was very complimentary about the practice and the care and treatment received. Patients told us staff were helpful, friendly, understanding and kind. The most recent results available from the national patient survey showed that 85% of patients who responded would recommend the practice to another. 87% said that they found receptionists at the practice helpful. 83% of respondents said that GPs were good at giving them enough time whilst 90% said the same of nurses. 85% of respondents said GPs at the practice were good at listening and treating them with care and concern. The percentage was the same in relation to nursing staff although at 85% this was below the local CCG average for nursing staff which was 91%. One young person in their late teens specifically commented that they were very shy and found it difficult to speak with their GP because of this. They told us they always felt they were listened to and that staff were very kind to them.

Patients said they were treated with dignity and respect. All consultations and treatments were carried out in the privacy of a consulting / treatment room. We noted that doors to rooms were closed during consultation and conversations taking place could not be overheard. We saw that privacy curtains were provided so patients' dignity was maintained during examinations, investigations and treatments.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Incoming telephone calls were taken in an office away from the reception area. The entrance to the practice was close to the reception desk but a line had been marked on the floor and patients were asked to wait behind it to maximise privacy for those speaking with reception staff. The reception area itself was spacious and seating was located as far from the reception desk as possible to prevent conversation being overheard. There was an area away from the main reception desk where patients could speak with a member of reception staff in private if they wished.

Care planning and involvement in decisions about care and treatment

Patients were encouraged and supported where possible to take responsibility of their conditions and to be involved in decisions about medication and other forms of treatment. The practice participated in the national expert patient model scheme through which they referred patients with diabetes for further learning about their conditions and self-management. One of the nurses told us this initiative had proved popular with patients and they had seen some very positive results.

Patients who completed CQC comment cards told us they felt listened to and that their opinion mattered. One person commented that staff were very thorough. Patients said they felt well supported by staff. Treatments and options were explained to them and appointments were not rushed.

In the national patient survey information we reviewed patients had responded positively to questions about their involvement in planning and making decisions about their care and treatment. Data from the survey showed that 80% of respondents said their GP involved them in care decisions and 84% felt their GP was good at explaining tests and treatments. In relation to nursing staff the results were 91% and 95% respectively. Overall 98% of respondents had confidence and trust in the last GP they saw or spoke with and 99% said the same of the nurses.

The practice was participating in an enhanced service aimed at avoidance of unplanned hospital admissions. They proactively reviewed patient data to identify vulnerable patients at increased risk and then agreed a care plan with the patient to reduce them. Examples included patients living in nursing or care homes, those with chronic conditions and dementia. The process was on-going and 245 care plans had already been completed.

The practice supported the electronic NHS summary care scheme and patients were able to view their own personal records through a secure facility on the practice website.

In one corner of the waiting area there was a self-check blood pressure monitor available to patients with instructions for use.

A translation service was available for patients who did not have English as a first language though we were told it was rarely accessed.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The practice had a proactive approach to engaging with the local community and supporting patients to cope emotionally. One patient commented that their GP had been instrumental in helping them through an exceptionally difficult time.

Literature in the waiting area and information posted on the website signposted patients to a number of support groups and organisations, for example, Carer's Point. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that families who had suffered bereavement were called by their usual GP and offered support. For example, by way of signposting relatives to support organisations such as CRUSE Bereavement Care and the Patient Advice Liaison Service (PALS).

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS Local Area Team (LAT) and Clinical Commissioning Group confirmed that the practice regularly engaged with them and other practices to discuss local needs and service improvements that required prioritisation.

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 patient population were understood and systems in place to address them. For example, there was no family planning clinic in the immediate locality and the nearest hospital was several miles away. The practice offered a number of enhanced services to benefit their patients such as minor surgery and contraception advice, including removal, insertion and review of coils. Other enhanced services included a comprehensive vaccination and immunisation programme, alcohol related risk reduction, near patient testing and extended hours access.

The practice had detected a prevalence of reluctance amongst the patient population to have vaccinations and discuss smoking status. In response to this they had devised a pop up prompt system on the computer system to encourage staff to take opportunities to revisit these issues with patients.

Longer appointments were available for those who needed them and those with long term conditions. Home visits were made to those unable or too ill to attend the practice. Care and nursing homes within the area had named GPs who routinely visited on a weekly or fortnightly basis to carry out a ward round.

The practice had a named GP who lead on palliative care. A palliative care register was maintained and there were regular internal and multidisciplinary meetings to discuss the care and support needs of patients and their families. Records showed that several members of clinical staff had completed training in end of life care.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment, for example, with the out of hours service.

We spoke with the Chair of the Patient Participation Group (PPG). They told us the practice listened to feedback from the group and tried to implement changes where possible. Examples included changes to the appointment system so routine appointments could now be booked up to six weeks in advance rather than two, introduction of an extra telephone line and online appointment booking facility, reception staff always introduced themselves by name when taking calls and a water dispenser had been made available in the waiting area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

In the car park bays closest to the practice had been designated for disabled parking. A ramp had been installed to facilitate wheelchair and pram access. Disabled toilets and baby change facilities were available. The waiting area was spacious and corridors sufficiently wide to accommodate wheelchairs and prams. A chair replacement programme was underway to ensure that some of the chairs in the waiting area had arms to assist those with restricted mobility to rise. Treatment and consultation rooms were clearly numbered and labelled with the occupant's name. Staff were able to access an interpreter to benefit patients for whom English was not the first language if required.

The practice had identified a high prevalence of chronic conditions such as COPD and diabetes amongst its patient population and adopted of chronic disease management initiatives to respond. These included additional training for member of the nursing team, a programme of chronic disease management clinics and the availability of enhanced services.

The practice had a comprehensive equality and diversity policy. Systems were in place for staff to access training in order to increase their awareness of matters such as domestic violence, dementia and learning disability.

The patient population had included a large group of travellers who had been registered at the practice but moved on several months ago. One of the GPs told how they had proactively engaged with the travellers by inviting representatives into the practice to welcome them to the service and manage their expectations of it. They told us they had developed a good working relationship with them as a result.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice opening hours at the main site were 7.30am to 8.00pm on Mondays, and 7.30am to 6.30pm Tuesday to Friday. Surgeries were available mornings, afternoons and evenings. Hambleton branch surgery was open each weekday morning. The opening hours at the branch varied but the core time was between 9.00am and 10.00am. When the practice was closed an out of hours service met the care and treatment needs of patients.

Comprehensive information was available to patients about appointments on the practice website and on notices displayed at the surgery.

Patients were able to book appointments in person, online or by telephone. Same day appointments were available for emergency consultations and routine appointments could be booked up to six weeks in advance. Telephone consultations could be arranged with both GPs and nurse practitioners. Home visits were arranged for patients who were too ill or unable to visit the surgery. GPs routinely visited local nursing and care homes to carry out ward rounds. In line with government guidelines the practice operated a triage system whereby receptionists asked preliminary questions in order to direct the patient to the most appropriate healthcare professional for their problem.

The electronic appointment system adopted by the practice offered flexibility to enable them to respond to changing demand on a day to day basis. Capacity and demand were under continual review.

At the time of inspection the practice had just completed their annual patient care survey and received 263 responses. Questions asked of patients included how easy they found it to reach the practice by telephone and 64% of respondents had said it was easy or fairly easy to do so. When asked if they were usually able to see their preferred GP 82% said that more often than not, or sometimes, they were able to do so. 18% of respondents said that on more than one occasion they had been told no same day appointments were available when they had felt strongly that their condition needed one. 74% said it was easy or fairly easy to book a routine appointment in advance. When asked to think about their recent experience of the service 77% said they were likely or extremely likely to recommend the practice to family or friends (10% of respondents had given no response or indicated that they did not know).

We were shown an action plan resulting from the practice's recent patient care survey. Over the next two months there was to be a full audit of patients attending the desk and telephoning the surgery, trends and peak times of telephone calls were to be established and an internal review of the triage system conducted.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. The complaints policy is in line with recognised guidance and contractual obligations for GPs in England. The practice manager was designated as the person responsible for handling complaints received and one of the GPs maintained an oversight. A notice was displayed in the waiting area explaining the complaints process.

We looked at records held in relation to two complaints received during the last 12 months. We found they were satisfactorily handled and dealt with in a timely manner. The practice maintained a summary record of complaints received. Recorded on this were the date of receipt, details of investigation, action taken, learning points and resolution. The summary was subject to regular review to detect emerging themes

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients and this was reflected in their five year business plan. Their stated purpose was to provide patients with personal health care of high quality and seek continuous improvement on the health status of the practice overall. Their aim was to achieve this and maintaining a happy sound practice which was responsive to patients' needs and expectations and which reflected wherever possible the latest advances in primary health care.

Governance arrangements

We found there was a strong governance structure in place.

The practice had a comprehensive range of policies and procedures in place to govern activity and these were readily accessible to staff on any computer within the practice. There were effective systems in place to ensure staff kept up to date with policy and procedure, and that any amendments were brought to their attention in a timely manner. All the policies and procedures that we looked at were comprehensive and clear. All policies and procedures were reviewed annually and were up to date.

Every two weeks the practice held a management meeting. We looked at minutes from the last two meetings and found that performance, quality and risks were discussed. The practice manager maintained a rolling log of actions arising from management meetings. This recorded the date of the meeting when the action had been agreed and a summary of it, the name of the individual(s) responsible for completion and the deadline for doing so. The action log was reviewed at each meeting to monitor progress and ensure timely completion.

A regular programme of meetings provided opportunities for the various staff teams to meet independently and as a group. Every three months the whole staff team attended a primary healthcare team meeting. Meetings were recorded. Having minutes which outline the content of meetings helps improve governance mechanisms and minimise the risk of staff misinformation or error. Minutes were circulated to relevant staff and signed off.

All staff were included in areas of responsibility such as monitoring appointments and introduction of systems to improve the smooth running of the practice. For example, audit of telephone calls received to establish trends and peak times of telephone calls with a view to improving patient outcomes.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed that it was a high performer against national standards. QOF data was regularly discussed at team meetings and action plans produced to maintain or improve outcomes. We saw the practice had completed a QOF enhancement audit which included thorough review of all chronic disease areas to highlight areas for improvement and raise awareness in clinicians, with a view to achieving better outcomes for patients.

The practice offered patients a total of 23 enhanced services to improve patient outcomes. There was a good mix of skills amongst the staff team and some members were trained to fulfil multiple roles. This enabled the practice to respond to changing priorities and demands. The practice manager regularly reviewed the non-clinical staff resource available to ensure it was used to optimum effect. For example, the practice offered an enhanced service in relation to avoidance of unplanned admissions and a member of the administrative team had been allocated to work specifically on this project to maximise results.

We found the practice was mindful of the need for succession planning.

The practice participated in a neighbourhood system promoted by the local Clinical Commissioning Group. This enabled them to compare their performance with that of similar surgeries in the area and share learning. For example, in relation to significant events and through peer review. They worked collaboratively with other local surgeries to improve outcomes for patients in the community. We were told that through this forum medicines management and nursing home protocols trialled by the practice had subsequently been rolled out across the neighbourhood.

The practice had completed a number of clinical audits over the last 12 months and further audits were in progress or planned. Examples of areas audited included chronic kidney disease, cardiovascular disease and uptake of the 2nd measles, mumps and rubella (MMR) vaccinations by children aged 3 to 5 years. Results were analysed, areas for

Are services well-led?

Outstanding ☆

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

improvement identified, actions to implement them completed and learning shared with staff as appropriate. As a result of the MMR audit the practice had introduced pop up prompts on the electronic record system so staff could issue timely reminders to parents when vaccination was due and telephone calls were made to parents to encourage them to book appointments. A follow up audit showed that the compliance rate had improved and the process was to be repeated annually.

The practice had robust and comprehensive arrangements for identifying, recording and managing risks. These included risks relating to the building, the environment, medicines management, staffing, equipment and a range of emergencies that may impact on the daily operation of the practice. Examples included flood, pandemic, fire and terrorism. We saw that risks to both service and staffing changes (both planned and unplanned) were included. Each risk was rated and mitigating actions recorded to manage and reduce risk.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in key roles. For example there were named GP leads for matters such as safeguarding, information governance, Clinical Commissioning Group liaison and the practice manager lead on health and safety. Reporting lines were well defined and understood. Staff we spoke with understood their roles and were clear about the boundaries of their abilities. They were aware of each other's responsibilities and who to approach to feedback or request information.

Staff told us they felt well supported and valued. We found that staff knew and understood the practice vision and values, and what their responsibilities were in relation to it. From our conversations with staff during the inspection it was clear the team was fully committed to achieving it with a can do approach. It was also clear the practice had a dedicated and cohesive team of staff who had mutual respect for each other.

Staff consistently spoke of an open and honest culture within the practice. There was a regular programme of team meetings. The practice manager told us that each primary healthcare team meeting included an open floor session for staff to make suggestions, provide feedback or raise concerns. Staff we spoke with confirmed such opportunities were available and that they felt comfortable in doing so.

The practice had a comprehensive range of human resource policies and procedures. These were readily accessible to staff and staff we spoke with knew where to find them. They included matters such as equal opportunities, equality and diversity, and whistleblowing.

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

The practice gathered feedback from patients through patient surveys, comment cards and complaints received. The practice had an active Patient Participation Group (PPG) which all patients were invited to join. One of the noticeboards in the waiting area was dedicated to information about the PPG and information was also available on the practice website. The PPG met at the practice every three months. Consideration was also being given to establishing a virtual group to encourage involvement by those unable to physically attend the meetings. The Chair of the PPG told us the practice was cooperative and supportive of them, and a good representation of staff from the various practice teams usually attended their meetings.

At the time of inspection the practice had just completed its annual patient survey. The PPG had been actively involved in this process, having determined the questions to be included. The results had been analysed by the practice, shared with the PPG and published on the practice website. The practice had formulated a draft action plan to address issues raised for discussion with the PPG at the next scheduled meeting on 14 January 2015. We saw that a number of reviews and audits were proposed with a view to further improving access to the service.

The Chair of the PPG gave us several examples of when the practice had responded to feedback and taken action at their suggestion. We were told that previously the practice had released a number of appointments for morning surgery and then more later in the day for the afternoon surgery. In response to PPG feedback the procedure had been changed so that appointments for both surgeries were now released together alleviating the need for a patient to call back later if the morning appointments were fully booked. Appointments could now also be booked up to six weeks in advance rather than two as previously. A water dispenser had been installed in the waiting area and

Are services well-led?

Outstanding ☆

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

disabled access improved by installation of a ramp and creation of dedicated parking bays closest to the door. Reception staff now always introduced themselves by name when answering the telephone.

We looked at one of the audits completed by the practice in relation to stroke prevention in atrial fibrillation. The practice had identified patients who could potentially benefit from anticoagulation and invited them to attend an integrated care clinic at the practice. We noted that in evaluating the results of the audit the practice had obtained patient feedback on their experience in attending the clinic. Patients had commented that it had been informative and reassuring. 100% of patients attending said they found the experience useful and 90% indicated they would attend a further clinic.

On the day of inspection we noted the practice had been proactive in encouraging patients to provide feedback on the service and contribute to the inspection process. The availability of comments cards was well publicised in the waiting area. The TV display screen also included a message to patients explaining the inspection was taking place and their feedback would be welcomed.

The practice gathered feedback from staff through appraisals and staff meetings. Staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. From reviewing minutes of meetings we saw evidence of brainstorming sessions with all staff encouraging them to share their ideas and take ownership of the service.

The practice had a whistleblowing policy in place which was readily accessible to staff. Whistleblowing is defined as the disclosure by an employee of confidential information which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace, be it of the employer or a fellow employee.

Management lead through learning and improvement

The practice had a clear understanding and commitment to the needs of staff. There were good development opportunities. We found there was a willingness to invest in people and develop existing staff wherever possible, providing opportunities for further qualification and skills. For example, two members of the nursing team had been trained to administer insulin, another was completing a business related masters degree. Individual members of the nursing team lead colleagues in relation to management of specific chronic conditions. They were encouraged to take responsibility and ownership of their respective areas but were supported in doing so by a named GP who retained an oversight. One nurse told us they had been with the practice for several years and had not stopped training during that time. Each nurse practitioner had a named GP mentor with whom they had a weekly clinical supervision session. Nursing staff told us the GPs were always accessible and very approachable. Staff consistently told us they felt valued and supported.

The practice participated in an apprenticeship scheme offering apprentices work training experience, for example in the dispensary and administrative teams. We were told of examples where this had subsequently led to an offer of permanent employment.

Newly employed staff completed a period of induction. Learning objectives for existing staff were discussed during annual appraisal and mandatory training was role relevant.

The practice completed reviews of significant events and other incidents. Practice documentation showed evidence of learning being shared across the practice. A structured programme of meetings provided a regular forum for this.