Priory Road Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Priory Road Medical Centre is a suburban practice providing primary care services to patients resident in Swindon. The practice has a patient population of approximately 8,400.

We undertook a comprehensive announced inspection on 14 October 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector, an additional CQC inspector and a GP specialist advisor.

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

The overall rating for Priory Road Medical Centre is good. Our key findings were as follows:

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

We saw several areas of outstanding practice including:

Summary of findings

- Priory Road Medical Centre demonstrated outstanding practice by participating in national research programmes through Primary Care Research Network.
- The practice also participated in pilot schemes which promoted self care for good health and well being such as the community navigator scheme and the telehealth systems.
- Priory Road Medical Centre was a local provider of diabetes education through the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme created for patients with Type 2 diabetes.
- The practice held a 'Carer's cuppa & drop in clinic' to support local carers and help them access additional support services.

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

The provider should:

- Undertake a risk assessment to identify the optimum place for the emergency equipment to be sited to make it accessible for the staff.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. There were enough staff to keep patients safe. The practice had a range of systems in place to ensure the safety of patients who used their practice. This included safe patient care and appropriate use of equipment to support the patient whilst in the practice. We found the practice learnt from incidents and complaints and improved day to day procedures to improve the services provided. Medicines were managed safely and prescribing medicines was monitored in line with current guidance. There were sufficient emergency medicines and equipment in place to ensure medical emergencies could be managed effectively.

Are services effective?

Good

The practice is rated as good for effective. The practice had systems and processes in place to ensure that standards of care were monitored and maintained. Best practice guidance was taken in to account and the practice ensured all staff had access to information about improving outcomes for patients. For example, clinical audits had been completed and patients were supported to manage their own health. Patients were satisfied with the treatment they received and told us appropriate health care management plans were put in place to support their health and wellbeing. Staff told us they were very well supported by the provider and had access to information and training which helped them develop as individuals and as part of the practice team. There were good working relationships with other providers and innovative ways of making services available to vulnerable groups of patients. Health promotion and prevention was provided in a targeted way and opportunistically by the practice which engaged well with patients.

Are services caring?

Good

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

Summary of findings

maintained. Discussion with patients on the day of the inspection provided positive feedback. All said that staff were extremely person-centred and they were always treated with respect and had confidence in the staff.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice reviewed the needs of its 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 and continuity of care, with urgent appointments available the same day. The GPs and nurses worked with patients to promote self-care and independence. 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 that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice was rated as good for well-led. There was strong leadership which cascaded a clear vision for the practice to the staff team. The priority for the practice was provision of a high quality, safe service for its patients. The leadership, management and governance of the practice assured the delivery of high quality, patient centred care.There was a clear leadership structure and staff felt supported by management. The service was proactive and effectively anticipated and responded to change. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group. Staff were encouraged to make suggestions for improvement. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns. All staff we spoke with felt valued and rewarded for the jobs they undertook and they were encouraged and trained to improve their skill sets. We found there was a high level of constructive staff engagement and a high level of staff satisfaction.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. The practice provided a named, accountable GP for all patients aged 75 and over. The practice worked collaboratively with other agencies to implement a range of monitoring and preventative measures such as telehealth and the community navigator pilot scheme. Monthly multidisciplinary meetings were held with community teams to discuss the most vulnerable patients. For patients requiring end of life care and support, a palliative care meeting was held every three months with the lead GP. The practice maintained a palliative care register of patients. It was updated as appropriate and the care needs of patients were regularly reviewed. The practice also supported older patients living in residential or nursing homes locally. In support of carers there were monthly meetings held to widen the services offered to carers and the people they cared for. Priory Road Medical Centre had a direct emergency phone line for care homes and other professionals.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of patients with long-term conditions. The practice provided specialist nurse support for conditions such as asthma, diabetes and heart disease. Patients' conditions were monitored and reviewed with planned appointments sent directly to them.

We found patients were assessed and signposted to the most appropriate support. For example, all newly diagnosed diabetic patients were invited to attend a locally arranged group course in managing their diabetes. The lead nurse had specialist knowledge and awareness of diabetes, and had developed and promoted insulin initiation, without the need for referral to the hospital. All of the practices diabetic patients attended a yearly review.

The practice promoted self-care and offered patients with long term conditions an assessment and education to use tele care systems for monitoring their condition. All vulnerable patients had a care plan which could include emergency medicines such as antibiotics or steroid therapy. The care plan was made available to the Out of Hours service.

Families, children and young people

Good

The practice is rated as good for the 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 patients who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us and we saw evidence that children and young patients were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. The practice liaised with a range of other agencies regarding patients for example, the sexual health clinic. Young adults were able to access confidential appointments with a GP.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients (including those recently retired and students). GP and nurse appointments were arranged to accommodate work commitments when required by patients. The practice had emergency appointments each day during extended hours, and planned appointments during extended hours including once a month on a Saturday morning.The practice also provided telephone consultations and an electronic prescription service to patients' nominated pharmacy. NHS health checks were offered to all patients aged 40-74. We found the practice participated in health screening programmes such as the national cervical cancer screening programme.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice had a system of identifying those patients in vulnerable circumstances who may have difficulty accessing services such as those with learning disabilities or those patients whose first language was not English. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. The practice had a number of agencies who were based within the building which were accessible by patients though self-referral, such as the psychology service or via GP referral, such as the substance misuse service.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including patients with dementia). The data provided by the practice showed 83% of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for patients with mental health needs and dementia. Patients at the practice had access to psychological therapies and self-help groups through psychology services ranged from self-help therapies, to psycho-educational courses and one-to-one support.

Summary of findings

What people who use the service say

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

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

- 97% of patients rated both 'involvement in decisions about care' and 'how well the doctors explained problems or treatment required' as 'good to excellent' compared to 92% in 2012.
- 93% of patients felt 'time spent with the doctor' was 'good to excellent' compared to 90% in 2012
- 97% of patients rated 'GPs' care and concern' as 'good to excellent' compared to 93% in 2012.

The survey results were corroborated by the comments made by the five patients we spoke with during our visit.

We also had 26 patients complete our comment cards. These showed a high level of satisfaction with all areas of the practice and included positive comments about staff being highly skilled, respectful and considerate and about GPs listening to patients and providing clear explanations.

In response to concerns raised by patients, the practice had recognised the high cost of telephone calls to the practice and had changed its contact number so calls to the practice were charged as a local rate call. Information about this change was posted on the practice website for those who used it and on the practice notice board for other patients.

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

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

The practice had a patient forum that consisted of approximately 17 members who represented the demographic make up of the practice population. The practice arranged regular meetings with these members to discuss any improvements that could be made to the practice. We spoke with two representatives who attended the forum. They told us the group had recently changed from being a virtual group to a group which had regular face to face meetings at the practice. We were told the practice had listened to the group and took their views into account when making decisions about the practice.

Areas for improvement

Action the service SHOULD take to improve

- The provider should undertake a risk assessment to identify the optimum place for the emergency equipment to be sited.

Outstanding practice

We saw several areas of outstanding practice including:

- Priory Road Medical Centre demonstrated outstanding practice by participating in national research programmes through Primary Care Research Network.
- The practice also participated in pilot schemes which promoted self care for good health and well being such as the community navigator scheme and the telehealth systems.

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- Priory Road Medical Centre was a local provider of diabetes education through the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme created for patients with Type 2 diabetes.
- The practice held a ‘Carer’s cuppa & drop in clinic' to support local carers and help them access additional support services.

Priory Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Priory Road Medical Centre

The practice is located at Priory Road in Swindon. The patient population of 8400 was predominantly white British. The practice is in an area of higher than average deprivation with higher than average unemployment. 25% of patients are under 18 years old and 12.5% of patients live with a long term health condition. The practice also supports patients in residential and nursing care homes. The patient participation group is made up of a representative mix from the patient group.

Priory Road Medical Practice has one location:

Priory Road Medical Practice

Priory Road

Park South

Swindon

Wiltshire SN3 2EZ

The practice is routinely open from 8.00am to 6.30pm on Mondays to Fridays. Extended hours start from 7.30am on Wednesday, Thursday & Friday, on two Monday evenings until 7.30pm every other month, and one Saturday morning a month. There are daily urgent care appointments for patients with an illness requiring same day medical care.

The practice operates as a partnership between five GPs and one salaried GP who works a total of 40 sessions across the week. The practice also employs three practice nurses. The practice does not offer Out-of-Hours care, but provides telephone information to patients about Out-of-Hours and emergency appointments that would be provided by another agency. This information is also available in the practice brochure and on their website.

The practice has a personal medical service (PMS) contract.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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.

Detailed findings

How we carried out this inspection

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

We carried out an announced visit on 14 October 2014 between 9am - 5pm.

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

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

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

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

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

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

The patient population group profile information provided by the practice was:

- Vulnerable older patients (over 75s) 8%
- Patients with long term conditions 12.5%
- Mothers, children and young patients 25% (under 18 years)
- Working age population and those recently retired 51%
- Patients experiencing poor mental health.1.5%
- Patients in vulnerable circumstances who may have poor access to primary care 1.8%

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example the practice had made a recent child protection referral which was fully documented by them. We reviewed safety records and incident reports and minutes of meetings which showed the practice had managed these consistently over time

The practice used an electronic patient record system. Any significant medical concerns or additional support needs were added as alerts to patients' records. These appeared when a record was opened and alerted the GP or nurse to significant issues relating to that patient and their care. For example, if a patient had communication difficulties or had missed an appointment. Staff also understood that patients may be supported by a carer or a relative to act as an advocate for them, and this information was recorded on the patient record.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred since July 2013 and these were made available to us. Staff told us incident records were sent to the practice manager. The practice manager was able to explain how incidents were managed and monitored. We tracked 10 incidents and saw records were completed in a comprehensive and timely manner. The practice had a system to put in place corrective action following incidents and to share learning with all staff. For example, GPs we spoke with were aware of their responsibility to complete a significant event form for investigation and action. We were told significant events were discussed as they arose in order to identify whether urgent action would be required. A slot for reviewing significant events was on the practice meeting agenda and a dedicated meeting took place every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff, including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and told us they felt encouraged to do so.

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

The GPs also told us how they dealt with drug safety alerts and how this impacted on their prescribing for patients. The practice had a summary of prescribing audits, which allowed it to monitor how drug safety alerts were implemented. The practice manager also received Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and took appropriate action as needed.

Reliable safety systems and processes including safeguarding

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

The practice's electronic records system had an alert mechanism so staff were made aware there were other

important issues to consider when these patients attended appointments. For example, if children had persistently failed to attend appointment for childhood immunisation. The practice also had a system in place to monitor patient attendances at accident and emergency centres and use of Out of Hours services and urgent care centres.

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

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We observed contact details were easily accessible around the practice. The GPs and nurses were aware of the Gillick competence requirements and ensured children were accompanied by an adult if they needed to see a GP or nurse. A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone, two receptionists had also undertaken training and understood their responsibilities when acting as chaperones.

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

Medicines Management

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

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

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under patient specific direction from a registered prescriber which had been reviewed and approved in line with national guidance and legal requirements. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers, who received regular supervision and support in their role, and had opportunities to update skills in the specific clinical areas of expertise for which they prescribed.

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

Good

Are services safe?

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

The practice set a target of getting medicines to patients within 72 hours. This included 48 hours to write the prescription and 24 hours for the pharmacy to receive and process it. This was overseen by one of the GPs so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the GPs read their discharge summary and make adjustments to the patient records. The GPs then pass to administrative staff for scanning onto the electronic system.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury.

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

Equipment

The practice was suitably designed and adequately equipped. The fabric and fixtures and fittings of the building were maintained are maintained by the practice as lead tenants. We saw equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED) centrally located and all staff were trained in its use.

All portable electrical equipment was routinely portable appliance tested (PAT) and displayed current stickers indicating testing. Single use examination equipment was stored hygienically and was disposed of after use. Other equipment was wiped down and cleaned after use. When equipment became faulty or required replacement, it was referred to the practice manager who arranged for its replacement. Equipment such as the computer based record system were password protected and backed up to prevent data loss.

Staffing & Recruitment

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

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they were enough staff on duty.

Good

Are services safe?

There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice was located in a purpose built environment which it leased and shared with three sub tenants. The maintenance of the actual building and external grounds was managed by the landlord. The health and safety of the building was managed by the practice. We were shown the systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative.

We saw that risks were discussed at GP partners' meetings and within team meetings. For example, the practice monitored repeat prescribing for patients receiving medicines for mental health conditions. We saw a range of information was available in the practice which provided details of organisations patients or staff could contact if physical health emergencies or mental health crises occurred, either during or outside of practice opening times. The reception staff showed us contact telephone numbers of relevant organisations they could contact and there was a detailed emergency incident procedure available.

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff had recently completed basic life support training and were able to tell us the locations of all emergency medical equipment and how it should be used.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children. We were told there was always a first aider and first aid equipment available on site when the practice was open. We found the emergency equipment and the defibrillator were in two separate locations and were not easily accessible to staff. There was no risk assessment of the accessibility of emergency equipment.

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

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

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

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

The building had a fire system and firefighting equipment, which was in accordance with the fire safety risk

Good

Are services safe?

assessment. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. Risks associated with service and staff were included on the practice risk log. We saw an example of this as the practice had identified 'a place of refuge' in case of fire, for a worker who was a wheelchair user.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of diabetes. We were also told about the research programmes the patients at the practice were involved in such as the BWeL Study. This was operated by the Clinical Trials Unit (CTU) at the University of Oxford. The aim of the study was to see whether Brief Intervention alone was a worthwhile tool in the management of obesity in adult populations. The study recruited suitable candidates through general practices for weight loss interventions. In this research programme, the surgery randomly selected candidates with Body Mass Index of 30+ for brief intervention and for locally run weight loss management programme.

There were processes for making referrals to specialist or investigative services. The GPs and practice manager confirmed to us urgent referrals were completed on the same day and others within a 48 hour window. We saw no evidence of discrimination when making care and treatment decisions and the practice operated a daily peer review of all referrals. Interviews with GPs informed us the culture in the practice was that patients were referred based on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for patients

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to monitor and report performance. The practice also participated in local benchmarking run by the clinical commissioning group. This was a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area.

The practice showed us six clinical audits that had been undertaken in the last year. Five of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit for example; patients had a change in prescribed medicine. 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) a national performance measurement tool. For example we saw an audit regarding the prescribing nonsteroidal anti-inflammatory drugs. Following the audit the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. The quality of the records of the purpose, process and outcomes was variable. Some audits followed the Royal College of General Practitioners (RCGP) guidance and others were a brief record of actions which lacked any details. The audit methods used did not always demonstrate this was a planned process which had contributed to the quality assurance at the practice.

The patients with long-term conditions we spoke to told us their conditions were well managed and routinely monitored and patients told us their health conditions had stabilised. We saw monitoring and management programmes for patients with long-term health conditions

Good

Are services effective?

(for example, treatment is effective)

such as diabetes, anaemia and coronary heart disease. Patients with these conditions had regular blood tests to monitor whether the level of medicines they were taking remained safe and effective.

The practice used the information it collected for the QOF and its performance against national screening programmes to monitor outcomes for patients. For example, 92.6% of patients with diabetes had an annual medicine review, and the practice met all the minimum standards for QOF in diabetes. This practice was not an outlier for any QOF (or other national) clinical targets.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs, with two having additional diplomas in contraception. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation had been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice provided training and funding for relevant courses, for example phlebotomy. Staff told us that because the practice was a training practice GPs who were in training were offered extended appointments and had access to a senior GP throughout the day for support. There was no GP in training when we visited the practice.

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

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

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

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, Out of Hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. The surgery had a process in place which enabled the GPs to follow up results or discharge summaries in the absence of their colleagues.

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

Good

Are services effective?

(for example, treatment is effective)

local voluntary groups. The practice held multidisciplinary team meetings at least three monthly to discuss patients with complex needs, for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The patients we spoke with told us they had been referred quickly to specialists and consultants for further tests or treatment. They also told us how they were referred to voluntary groups for support at times, as well as community nursing services. Patients told us they had received test results promptly and had discussed with GPs and nurses their options for ongoing treatment and support. The records system used by the practice allowed for blood results and information from other healthcare providers to be recorded. For example, discharge letters were scanned onto the system and were available to GPs and nurses.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, the practice operated a shared care system with Out of Hours services for vulnerable patients, those who may be at the end their life or for those acutely unwell who may need out of hours support. They ensured care plans were updated and accessible. Staff felt this process promoted continuity of care for patients and reduced hospital admissions. Electronic systems were also in place for making referrals. The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

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

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where mental capacity was an issue, the practice had made guidance available to help staff, for example with completion of do not attempt resuscitation orders. The guidance stated how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make decisions.

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

Health Promotion & Prevention

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

Good

Are services effective?

(for example, treatment is effective)

preventing heart disease, cervical screening, and breast screening. Routine health checks were available for diabetes, hypertension and prostate problems and routine and opportunist screening was available for chlamydia, dementia and cervical cancers. The practice also offered health promotion advice and counselling for a variety of issues such as substance and alcohol misuse and contraception.

The practice offered a variety of screening programmes for patients. It was practice policy to offer all new patients registering with the practice a health check. The GP was informed of all health concerns detected and these were followed-up. We were told the practice lead nurse was proactive in assessing and testing all patients for diabetes. The lead nurse was also a DESMOND trainer (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) and helps patients to identify their own health risks and to set their own goals for managing those risks. The practice hosted training sessions for the area.

Information advice about treatment options was available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support via the practice website. The practice was aware of the local initiatives for health improvement from Swindon Council and Swindon Clinical Commissioning Group (CCG) and had accessed them for patients registered with the practice.

The practice identified patients who needed additional support, for example, the practice kept a register of vulnerable patients including those with learning disabilities, dementia, mental health conditions and patients in nursing homes. Practice records showed 83% of patients on practice mental health register had physical check-up since March 2013. The practice had a higher than average dementia diagnosis through cognition testing but also participated in the local Dementia Identification Scheme which shared information about patients to relevant services. The practice had also identified the smoking status of 54% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to 100% of these patients.

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The patients we spoke with about the practice praised the treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We were told that nursing staff offered support and reassurance to patients when they received unpleasant or painful treatment.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 300 patients undertaken with the practice's patient participation group (PPG). The evidence from this group 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 85% of patients rated the practice as good or very good. This was comparable to other practices within the clinical commissioning group area. We received 26 comment cards from patients and the majority were positive about the service experienced at the practice. We also spoke with five patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We observed the reception staff treated all patients with dignity and respect when they arrived for appointments. Patients were greeted in their preferred manner and medical conditions were discussed confidentially. The practice had a self-service booking-in system at reception however, receptionists checked that patients were able to use it successfully and were on hand to provide help. The reception area was at one end of the waiting area which further aided patient privacy.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. A system was in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in 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. When patients were called for appointments, the GP or nurse came out to collect the patient and welcomed them by name. Where patients had poor mobility they supported the patient in getting into the treatment room. All patients were seen in private, unless they chose to be accompanied by a partner, parent or chaperone. All consultation rooms were separated from the waiting area and had locks on doors. We did not see any staff enter them unannounced during our inspection.

We were told that the practice had a whole practice approach to supporting patients following bereavement. Staff described how they worked with the community nurses team to arrange telephone contact and support visits to ensure patients had the support they needed. We were also told that the practice supported patients with complex health needs by offering regular follow-up and review appointments, and specialist nurse clinics for long-term health conditions. End of life care was closely monitored in partnership with the community nurses and responsive visits were made as needed.

Care planning and involvement in decisions about care and treatment

We found patients at the practice were able to express their views and were involved in making decisions about their care and treatment. We observed and were told by patients how they were involved in their care and treatment. Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their

Good

Are services caring?

care and treatment and generally rated the practice well in these areas. For example, data from the patient survey showed 97% of practice respondents said the GP involved them in care decisions and 97% felt the GP was good at explaining treatment and results. Patients told us that their GP consulted with them about the choices of treatment available to them and how that treatment could be provided.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated the practice highly in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the practice website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was information available for carers to ensure they understood the various avenues of support available to them. The practice also hosted a 'Carers Cuppa' session once a month when carers could visit the practice and meet other carers. The sessions were supported by a dedicated support worker.

Staff told us that every patient death was discussed by the GP team and families who had suffered bereavement were called by the practice. The outcome of these calls was either followed by a patient consultation at a flexible time and location to meet the family's needs or signposting to a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' 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. There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes and for patients who could not attend the practice. For younger patients we found appointments available outside of school hours for children and young patients and the practice had extended hours for those patients who worked.

We observed that the waiting area of the practice had distinct seating areas and a variety of seating. For example, there was raised seating for older patients or those with mobility problems. The waiting room was spacious with easy access for patients who maybe wheelchair users, or parents/carers with pushchairs. We found the practice had separated off the reception desk from where patients queued which ensured discussions were private.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). For example, we heard that one member of the PPG had queried the 'disabled toilet' signage stating that it was an accessible toilet facility which should be available to any patient, i.e. a mother with a pushchair. We saw the signage on the toilet had been changed.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular multidisciplinary meetings to discuss patients' and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

To promote continuity of care for these patients, every patient over 75 years had a named GP. The practice also had care plans for all patients over 75 with long term conditions and/or on the 'at risk' register. We found the practice was working in partnership with the community matron to promote tele health systems which used technology to provide services that assist in the management of long term health conditions. The tele health system enabled individuals to take more control over their own health, by allowing them to monitoring vital signs, such as blood pressure, and transmitting the information to a tele health monitoring centre. The results were monitored against parameters set by the individual's GP and flag up problems or issues before they needed urgent medical attention.

We were also told about the pilot community navigator project initiated by Swindon Clinical Commissioning Group in which the practice participated. This included a healthcare practitioner who worked with patients in the community who lived with long term conditions. The practice worked collaboratively with the community navigator to identify support and equipment which enabled patients to manager their condition and live independent lives. For example, we were told about on patient who had been provided with an alternative mattress for their bed which had a consequence of promoting circulation to the patient's leg ulcers.

Information available in the practice promoted good health and wellbeing and the teams worked with patients to promote self-care and independence. Follow up telephone calls were made to patients with long-term conditions to ensure they were following clinical guidance and to remind them to attend their appointments. We were told that it was practice policy to make contact with every patient on the 'at risk register' who had been discharged from hospital to ensure patients had sufficient support for their recovery and to highlight any significant changes in their care or treatment.

There were processes for referring patients to specialist care such as a depression scoring system for assessing suicide risk and referral to mental health services. GPs had undertaken training in the Mental Capacity Act 2005 and had completed further research and reading relevant to safeguarding issues.

Tackle inequity and promote equality

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had suitable facilities to meet patients' needs. All of the practice consulting rooms were on the ground floor however there was also lift access to the first floor. The practice ensured the environment and facilities were appropriate and that the required levels of equipment were available in all consulting and treatment rooms. For example, the practice had installed electronically operated doors at the entrance to the practice. There was information at the reception desk for staff to use in case they needed to access an interpreter for a patient whose first language was not English. We also saw information for patients about accessing interpreters.

The practice had recognised the needs of different groups in the planning of its services. We observed that an area of the reception desk had been lowered which allowed patients who were wheelchair users to be spoken to on their level rather than be spoken down to. We also saw that the practice had produced information in an accessible format for patients with learning disabilities.

We were told by the practice manager that the practice had a large number of patients of Nepalese origin registered with them. The practice were aware patients from this ethnic group had a high risk of developing diabetes, and were aware there was a low take up of health screening amongst this group of patients. In order to address these issues the practice manager was working with a community worker for the Nepalese community to translate information and to provide guidance to the practice about any specialist cultural issues.

The practice maintained a register of patients whose circumstances made them vulnerable and this was flagged on individual patient records. The practice provided equality and diversity training and we observed information relating to equality and diversity around the practice. Patients were asked about their preferences and specifically whether there were any cultural or religious beliefs that would affect the care or treatment they received, for example gynaecological procedures or the gender of the consultant.

Access to the service

The practice was routinely open from 8am to 6.30pm on Mondays to Fridays. Extended hours started from 7.30am on Wednesday, Thursday & Friday, on two Monday evenings until 7.30pm every other month, and one Saturday morning a month. Appointments were available for on the day urgent care and planned appointments. Patients who used the practice told us they were able to contact the practice to make an appointment. Appointments could be made by telephone, in person or by using the practice's new online appointment booking system. Patients told us they were offered a choice of GP and GPs and nurses of both genders were available.

Opening hours were clearly visible at the entrance to the practice, in the practice's brochure and their personal and NHS Choice website. The appointments system was monitored to check both how it worked and where non-attendance occurred. Patients were able to be assessed by a GP by attending an appointment at the practice, including urgent appointments if needed, or through telephone consultations and home visits. A range of appointment slots were available, from short telephone conversation consultations to 10 minute single and 20 minute double appointments. Longer appointments were also available when minor surgery was being provided. The practice could send text reminder to patients about their appointment.

Routine recall appointments alerts were entered into the patient record system as a way of monitoring patient care and treatment. The alerts were used as a prompt to remind patients to have their medical conditions reviewed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw there was a complaints leaflet in reception to help patients understand the complaints system. The practice's complaints procedure was also promoted on its website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at five complaints received since 1 January 2014 and found these were investigated and dealt to the patient's satisfaction. The management team at the practice told us they learnt from complaints and made changes to prevent any reoccurrence. The practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Are services well-led?

Good

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

Our findings

Vision and Strategy.

The practice manager told us the vision and objectives of the practice had been publicized in the statement of purpose for the practice. Staff were able to tell us about the values and philosophy of the practice, which included key concepts such as compassion, dignity and respect, equality. The priority of the staff was to maintain a good standard of care to patients and to continue to develop additional services to support patient health. We found changes in the GP partnership had been discussed and plans were in progress to minimise disruption of services for patients.

Leadership, openness and transparency.

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. The members of administrative staff we spoke with told us there was good communication within the practice, with feedback accepted by the partners and the practice manager. Staff confirmed the senior partner and the practice manager were very approachable and actioned any issues that had been raised with them. We were told by the GPs there was good communication between the team and the staff had an informal meeting each morning where any issues or concerns could be raised. The health visitors and community nurses confirmed to us they were aware of this meeting and they could attend if necessary. The practice supported new GPs by informal mentoring by a colleague who provided support and feedback when needed.

The practice manager took lead responsibility for the day-to-day management of the practice and acted as a link between the GPs, staff and patients. The lead practice nurse had responsibility for the nursing team. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other, and said this made them more confident about proposing new ways of working. We found that staff were encouraged to develop additional clinical skills and roles. For example, the lead practice nurse had completed training in diabetes care and acted as the point of contact for all diabetic patients. The nurses we spoke with told us about the initiatives they had implemented for patients with diabetes, which had resulted in fewer attendances at the practice and a reduction in hospital admissions for patients.

The practice minuted practice meetings where developments and new guidance were discussed. We found that responsibility and accountability was clear among the partners of the practice. The GPs in the practice told us they operated an informal monitoring and mentoring system through their daily meetings. They felt this allowed a safe forum to challenge diagnoses and treatment. However more formal processes were in place, if required, to address concerns. The senior partner shared responsibilities with the other GPs. The GPs told us they felt complaints were dealt with following the agreed protocols and they tried to work with patients when things went wrong so both the patient and practice could learn together.

Governance Arrangements.

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

We found from talking to staff that governance was seen as a universal responsibility. There was an expectation staff would share the responsibility for difficult situations through discussion with others. To facilitate this, the GPs had an informal meeting between themselves each morning. The staff we spoke with were clear about what decisions they were required to make, knew what they were responsible for and fulfilled their role. For example, one nurse took responsibility for checking emergency medicine expiry dates and we saw this check was carried out.

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

The practice ensured any risks to the delivery of high-quality care were identified and mitigated. . The practice routinely gathered feedback from patients via

Are services well-led?

Good

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

suggestions and questionnaires and used this information to improve. We were told by the practice manager that they used audits to inform their own governance reporting and action plans.

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

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

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

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

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

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training to be given around chaperoning at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff.

We spoke with a range of staff including four GPs, the lead practice nurses, the practice manager, reception staff and the administrative team. All the staff we spoke with told us they felt involved in the day to day running of the practice, as well as the longer term functions of the practice. We saw records which showed staff were involved in staff meetings and discussed a range of practice issues. The minutes from these meetings showed staff were involved in the planning and changes in practice delivery. Some of the receptionist team had multiple roles in the practice, for example assisting with phlebotomy. Staff in these roles told us this enabled them to be more involved with patient care and could pass on observations to the teams.

Management lead through learning & improvement.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. The practice routinely considered improvements to its' services and used feedback from the patient participation group. There were measures in place to learn from incidents. We saw that this learning was passed on at staff meetings.

Where complaints were received about staff or other aspects of the practice, the practice manager spoke with those involved and offered them support to improve their performance. Performance was also discussed and reviewed at annual staff reviews. Staff training included mandatory subjects such as basic life support, fire training and safeguarding children and vulnerable adults. Staff told us they felt supported by the practice manager and the partners in the practice, and that the team was approachable and responded well to any queries raised by administrative staff. We were told there were sufficient staff on duty at all times to ensure patient needs were met. We were told that the practice manager and the senior partner led the management team well.