Drs Easton, Colgate, Richter & Flowerdew

Quality Report

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Date of inspection visit: 7 May 2015
Date of publication: 30/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an inspection of Orchard Surgery on 4 September 2014 and at that time we found that some improvements were required. We found that annual staff competency assessments for dispensing were not completed. We found that the complaints systems was not clearly brought to the attention of service users. In addition we found that significant events, complaints and incidents were not managed in a systematic and standardised way to identify risk and share learning across the whole team.

We carried out an announced comprehensive inspection at Orchard Surgery on 7 May 2015. The practice had introduced systems and processes to ensure its significant event, incident and complaints procedures were reviewed and any learning needs identified and shared with the whole practice team. In addition we saw relevant training and annual assessment of competence had been completed for staff. Overall the practice is rated as good.

We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

Our key findings across all the areas we inspected were as follows:

- The practice was a friendly, caring and responsive practice that addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned for.
- Patients said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should

Improve the arrangements for the security of medicines waiting to be collected and the security of blank prescription forms.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and report significant events or other incidents. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed and there were effective arrangements to identify and respond to potential abuse. Medicines were managed safely and the practice was clean and hygienic. There were enough staff working at the practice and staff were recruited through processes designed to ensure patients were 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. Guidance and standards issued by the National Institute for Health and Care Excellence (NICE) and other bodies was referenced and used routinely. Patient needs were assessed and care was planned and delivered in line with current standards and legislation. This included assessment of people's capacity, the promotion of good health and the prevention of ill-health.

Staff were properly qualified and trained appropriately for their roles and further training needs were identified and planned. The practice carried out appraisals of staff to ensure they were competent and had opportunities for development. Effective multidisciplinary working arrangements were in place.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice highly. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality. Support was available at the practice and externally for those suffering bereavement or that had caring responsibilities for others.

Are services responsive to people's needs?

Good

The practice is responsive to people's needs and is rated as good.

Summary of findings

The practice reviewed and understood the needs of their patient population particularly those who were at risk of unplanned hospital admissions. The practice ran a proactive care register for those who were most at risk and provided personalised care plans for this group of patients.

Patients reported good access to the practice with urgent appointments available the same day as well as late appointments Wednesday evenings.

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.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The practice had a clear vision and philosophy of care. Staff were clear about the vision and their responsibilities in relation to it. There was a clear and visible leadership with an effective governance structure. Staff felt supported by management. The practice held daily, morning coffee meetings to which all available staff were invited and encouraged to contribute their views to the running of the practice.

Policies and procedures were in place to govern the practice's activity and there were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and this had been acted upon. The practice had an active patient forum. The practice had an open, transparent, learning culture.

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 population group of older people.

Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. The practice liaised with the local community consultant geriatrician to review patients' medications and undertake health checks. Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for their care. The practice held monthly multidisciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and the community palliative care teams, to discuss vulnerable and complex patients and review future care needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice held monthly multidisciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and community palliative care teams to discuss vulnerable and complex patients and review future care needs.

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 were in-line for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. On the day telephone appointments were available and patients could specify when they

Summary of findings

would be available to speak with the GP. For example outside of school hours or during a coffee or lunch break. The premises were suitable for children and babies. We saw good examples of joint working with midwives, school nurses and health visitors. The practice encouraged attendance and education for childhood immunisation in particular for those patients and families from the local travelling communities.

Antenatal care was referred in a timely way to external healthcare professionals. Mothers we spoke with were very positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The appointment system met their needs. Appointments could be booked on-line. Health promotion advice was readily available including smoking cessation, healthy eating and alcohol consumption.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable.

Double appointment times were offered to patients who were vulnerable or with learning disabilities. All patients were able to register at the practice as temporary residents, regardless of their personal circumstances, including the homeless and members of the travelling community. Carers of those living in vulnerable circumstances were identified and offered support including signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. A lead for safeguarding monitored those patients known to be at risk of abuse. All staff had been trained in safeguarding and were very aware of the different types of abuse that could occur and their responsibilities in reporting it. The practice held monthly multidisciplinary team (MDT)

Summary of findings

meetings attended by GPs, district nurses, practice nurses and school nurses, health visitors and community palliative care teams to discuss vulnerable and complex patients and review future care needs.

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).

The practice was aware of the number of patients they had registered who had dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and then on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations and referred to other professionals for counselling and support according to their level of need.

Summary of findings

What people who use the service say

The practice provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 14 comment cards; all the cards indicated that patients were satisfied with the support, care and treatment they received from the practice.

Comments cards also included positive comments about the services available at the practice, appointment availability, the skills of the staff, the treatment provided by the GPs and nurses, the cleanliness of the practice, the support and helpfulness of the staff and the way staff listened to their needs. Patients recorded they were extremely happy with the care and treatment they received. These findings were also reflected during our conversations with patients during our inspection.

The feedback from patients we spoke with was extremely positive. Patients told us about the ability to speak or see a GP on the day and where necessary get an appointment when it was convenient for them with the GP of their choice. We were given clear examples of effective communication between the practice and other services. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing, reception and the management teams were all very approachable and supportive. We were told they felt confident in their care and liked the continuity of care they received at the practice. The patients we spoke with told us they felt their treatment was professional and effective and they were very happy with the service provided. They told us things were clearly explained to them and clinicians gave them sufficient time during consultations and information to be able to make decisions about their treatment and care without feeling pressured. Patients told us that all the team were very supportive and that they thought the practice was very well run. Patients told us if they needed to complain they would speak to the reception team or the management team. We were told they felt their concerns would be listened to.

Patients told us they were happy with the supply of repeat prescriptions. All the patients we spoke with told us they would happily recommend the practice and its facilities to other patients.

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for the security of medicines waiting to be collected and the security of blank prescription forms.

Drs Easton, Colgate, Richter & Flowerdew

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, a GP specialist adviser, a practice manager specialist adviser and a practice nurse specialist adviser.

Background to Drs Easton, Colgate, Richter & Flowerdew

Drs Easton, Colgate, Richter & Flowerdew also known as Orchard surgery provides primary medical services to around 7,500 patients living in the village of Melbourn and the surrounding rural area. The premises are purpose built. Parking is available beside the surgery.

The practice has a team of six GPs meeting patients' needs. Five GPs are partners meaning they hold managerial and financial responsibility for the practice. There are three practice nurses who run a variety of appointments for long term conditions and family health. In addition there are two healthcare assistants.

There is a practice manager, a dispensary supervisor, a team of dispensers and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements. A health visitor is attached to the practice and a community midwife runs weekly sessions there.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.30am and 6.00pm, Monday to Friday with additional hours from 6pm to 8.15pm Wednesday evenings. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with 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.

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?

Detailed findings

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 that we held about the practice and asked other organisations to share what they knew. During our inspection we spoke with a range of staff including GP partners, practice nurses, the health care assistant, the senior dispenser, the dispensary team, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff told us about the two new books on reception for compliments and concerns; staff described the compliments from patients, but were all clear that no concerns had been logged recently.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last twelve months. There was evidence of new systems in place to review and monitor incidents. Staff told us they felt these were working well. This showed the practice had put plans in place to manage incidents consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events and complaints and the learning from them was discussed at staff meetings and monitored for common themes and trends. There was evidence that the practice had learnt from these and that the findings were shared with relevant staff. We found staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. Not all the staff we spoke with knew of the location for these forms; however they were aware of the forms and the systems for raising a concern. The practice manager showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example where a patient had stopped taking medication abruptly. We saw that following this incident, clinical staff had reviewed procedures for this type of medicine and the advice given to patients. We saw records of meetings where this was reviewed with clinical staff. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were disseminated to all clinical staff electronically and discussed daily and at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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 made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing, administrative and reception staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. 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. The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern.

Patient's 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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to

make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans, patients diagnosed with dementia or those requiring additional support from a carer.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us that nursing staff were mostly used when chaperoning a patient. Disclosure and Baring Service checks had been undertaken for clinical staff. The practice manager described to us the process for risk-assessing non-clinical staff to determine their eligibility for a DBS check we saw these were documented in the staff members' personnel files.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or patients with a diagnosis of dementia or those requiring additional support from a carer. There were systems in place to follow up children who persistently failed to attend appointments. For example for childhood immunisations. One GP described how the practice encouraged attendance and education for childhood immunisation in particular for those patients and families from the local travelling communities.

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary itself was well organised and operated with adequate staffing levels.

The senior dispenser told us that members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly. At our last inspection in September 2014 we found that annual staff competencies for dispensing were not being done. On this inspection, we looked at staff training files for five dispensary staff, we found they all contained evidence of relevant training and all had evidence that an annual assessment of competence was completed.

There were arrangements in place for the security of the dispensary so that it was only accessible to authorised staff. However, we saw that completed prescriptions were stored in an unlocked cupboard and we were not assured that the security of this arrangement had been assessed. There was therefore a risk that medicines could be accessed by people they were not prescribed for.

The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. We looked at the annual return of performance against the DSQS standards and were assured that dispensing performance was of a high standard.

A policy and procedure folder was available in the dispensary for staff to refer to about standard operating practices. We saw that procedures were updated regularly, and records showed that staff had read the procedures relevant to their work.

We saw that there were arrangements in place to record and follow up medicine related incidents and drug safety alerts.

Patients were offered a choice of methods for requesting repeat prescriptions. We saw that this process was handled well by dispensary staff to ensure patients were not kept waiting unduly for their medicines. We saw that some prescriptions were not signed before they were dispensed but procedures were in place to minimise risk to patients by having them signed at the end of the surgery session.

We found that there were arrangements for the secure storage of blank prescription forms. However the security and record-keeping practices were not in line with national guidance and we could not be assured that if prescriptions were lost or stolen this could be promptly identified and investigated.

The practice had suitable arrangements for the storage, recording and disposal of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff.

Good

Are services safe?

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice to be 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. Bags and gloves were available for staff to use when handling specimens.

There were infection control policies in place. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury. We found staff had received induction training in infection control and the spillage kits were in date and accessible.

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

The practice had undertaken investigation and testing of legionella (a germ found in the environment which can contaminate water systems in buildings). However the practice had not undertaken regular checks in order to reduce the risk of infection to staff and patients. We discussed this with the practice manager who confirmed to us following the inspection that these checks would be regularly undertaken in line with the practice policy.

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 logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example blood pressure monitors and weight measuring scales.

Staffing and recruitment

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

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular daily checks of the building and the environment.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions or those at the end of life. There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as severe weather or staff illness. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis.

Good

Are services safe?

Staffing establishments including staffing levels and skill mix were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and appropriate levels of staff well-being.

Staff told us they felt happy they could raise their concerns with the practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role. Staff described what they would do in urgent and emergency situations.

Emergency medicines and equipment were available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly.

We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

Staff confirmed if they had daily concerns they would speak with the GPs, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinicians in the practice.

There was information displayed in the reception area, in the patient leaflet and practice website regarding urgent medical treatment outside of surgery hours.

Arrangements to deal with emergencies and major incidents

We saw records which demonstrated that both clinical and non-clinical staff had received training in Basic Life Support within an appropriate time frame. All staff we asked knew the location of the Automated External Defibrillator, oxygen and records we saw confirmed these were checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included access to the building, power failure, unplanned illness and adverse weather conditions. The document also contained relevant contact details for staff to refer to.

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. Staff told us regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. We saw that practice management meetings included discussions on expected standards of care. New information or guidance from the Clinical Commissioning Group (CCG) prescribing committee or quality standards from the National Institute for Health and Care Excellence (NICE) were assimilated during these discussions. As a result, the practice's management plans and protocols for particular conditions or treatments were updated and put into practice.

The practice's daily, informal coffee meetings, held for all available staff after the morning's surgery, also created a forum for staff to discuss clinical issues that had arisen during the morning's sessions.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw the practice completed reviews of case notes for patients for example with diabetes to show they were on appropriate treatment and had received regular reviews of their health and medicine.

The GPs told us they led on all specialist clinical areas such as diabetes, family planning and the management of chronic lung conditions such asthma and chronic obstructive pulmonary disease (COPD). Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Our review of the multidisciplinary team meetings and clinical meeting minutes confirmed that this happened.

We saw the practice had a clear system in place to manage referrals in a timely and effective manner. The practice addressed prescribing practices by individual GPs and they were continuing to actively monitor their performance through further audit cycles.

The practice used computerised tools to identify patients with complex needs. These patients had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. Patients were assessed individually according to the risks they presented with and changes made as appropriate to their care plans.

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

Management, monitoring and improving outcomes for people

The practice actively ran regular searches using their computer system to help them to manage their performance in the diagnosis and treatment of common chronic conditions and to assess their quality and productivity. The practice had taken steps to assure the reliability of the data produced by these searches by using particular software and standardised read codes that ensured accuracy. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results.

The practice had a system in place for completing clinical audits. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented in order to assess their effectiveness. We saw audits were also generated on a regular basis as a result of CCG initiatives, for example, infection control audits and prescribing such as methotrexate (a medicine prescribed for treating certain diseases associated with abnormally rapid cell growth) and proton pump inhibitors or PPIs audits. PPIs are a group of drugs whose main action is a pronounced and long-lasting reduction of gastric acid production. We saw that as a result of the audit on PPI prescribing, GPs had contacted patients to discuss any contraindications and review their medicine. We saw protocols in place to ensure patients were contacted following audits of medicines, made aware of changes and involved in their medicine review.

Good

Are services effective?

(for example, treatment is effective)

Following clinical audit cycles we saw that the outcomes had been discussed and agreed at clinical meetings and the practice was able to demonstrate the learning and changes following the initial audit.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. There were systems in place to identify patients at risk who had not attended for health reviews or flu vaccinations. Alerts were added to patients' computer records to notify the clinician if these were overdue. This ensured the clinician would be aware and able to undertake the review or vaccination should the patient arrive for an appointment for a separate healthcare need. The information staff collected was then collated by the GPs to support the practice to carry out clinical audits.

There was a protocol for repeat prescribing which was in line with national guidance. Patients receiving repeat prescriptions had been reviewed by the GP. Medicines were reviewed annually or more frequently when necessary. Repeat prescriptions were not issued until the patient had attended the practice for their medication review. All new prescriptions were checked and authorised by one of the GPs prior to being given to a patient.

The practice had implemented systems for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We looked at the minutes of the palliative care and end of life meetings and found that individual cases were being discussed and care and treatment planned in line with patients' circumstances and wishes.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs

Effective staffing

The Care Quality Commissions inspection conducted on 4 September 2014, found that not all staff competencies for dispensing were undertaken. On this inspection, we looked at staff training files for five dispensary staff and, we found they all contained evidence of relevant training and all had evidence that an annual assessment of competence was completed. Practice staffing included clinical, managerial, dispensing, reception and administrative staff. We viewed training records and found that all staff had received annual basic life support and safeguarding of children and vulnerable adults. Staff had also been trained in the use of the equipment used at the practice.

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

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed these included reviews of performance and the setting of objectives and learning needs. All of the GPs within the practice had undergone training relevant to their lead roles, such as adult and child safeguarding and family planning.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, practice nurses provided asthma and chronic obstructive pulmonary disease (COPD) monitoring, cervical cytology and administration of childhood and travel vaccines. We saw that the practice nurses and healthcare assistants had been provided with appropriate and relevant training to fulfil their roles. For example the administration of vaccines, cervical cytology and managing and supporting patients with long term conditions such as diabetes.

Good

Are services effective?

(for example, treatment is effective)

Reception and administrative staff had undergone training relevant to their role. Staff described feeling well supported to develop further within their roles. For example one member of the reception team had undertaken training as a phlebotomist (a person trained to draw blood from a patient for clinical or medical testing). This member of staff, with support from the practice was developing their skills further and training as a health care assistant. We saw evidence of other staff training, for example medical terminology, understanding cytology (the medical and scientific study of cells). Staff told us these were a big learning curve but the practice manager and GPs were very supportive. We noted a good loyal skill mix among reception, dispensing, administrative, dispensing and clinical teams.

Orchard surgery took part in teaching medical students in their last year of medical school, learning about working in the teams that deliver care in the NHS as well as the clinical aspects of caring for sick patients.

Working with colleagues and other services

The practice worked with other service providers to meet patient's' needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital admissions and discharges, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received by the GPs.

The practice held daily morning breaks including all staff which allowed for informal opportunities to discuss care and treatment and seek advice from colleagues. All patient referrals were peer reviewed by another GP to ensure they were appropriate and that alternate pathways had had been considered by the original GP. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients. For example those patients with end of life care needs or children on the at risk register. These meetings were attended by district nurses, school nurses, health visitors, community matrons and palliative care nurses. We saw the practice mental health lead liaised with a local dementia consultant to discuss patient care planning, health investigation and medicine management. Decisions about care planning were documented in a shared care record. There was a comprehensive system for managing results and discharge summaries and updating patient records and repeat medicines.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice had comprehensive systems in place to manage patients who were either about to access or had accessed secondary care (hospital). The practice was proactive in monitoring referrals to and reviewing patients recently discharged from secondary care. For example, the practice followed up a two week referrals to make sure it had been received and an appointment confirmed. Electronic systems were also in place for making referrals, through 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 appointments in discussion with their chosen hospital). One member of staff had developed a spread sheet to highlight the pathway for each referral. This ensured the practice were alerted of any patients whose referral had not been followed up. Staff reported that this system was easy to use. Clinical staff confirmed they used national standards for the referral of patients with suspected cancers.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The staff told us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, 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.

Good

Are services effective?

(for example, treatment is effective)

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

Consent to care and treatment

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. 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 a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a consent policy for staff to refer to that explained the different types of consent that could be given. For example, for all minor surgical procedures, the completion of a consent form was required. This covered the understanding of the procedure and any risks involved with it. Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and teenage health reviews, sexual health advice and free condoms. Patients who smoked were encouraged to see the practice nurse who had received training to support those who wished to give up smoking.

Staff showed us and told us about the new patient's registration pack which included a new patient health questionnaire, a patient ethnic origin questionnaire, a medication information questionnaire, consent of patient care data information sharing and an opt out request for patients from the NHS Summary Care Record. Clinical staff told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

The practice offered NHS Health Checks to all its patients aged 40-75 and these checks were undertaken by the practice nurse. The performance of the practice in this area was the subject of regular monitoring and data reflected that targets were being achieved.

The practice identified patients requiring additional support. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. These patients attended appointments or were seen in their own home by the GP or nurse for their annual review of their condition and their on-going treatment was followed up by the practice. Care plans in place were regularly reviewed.

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice was pro-active in identifying patients through posters in the surgery the information screens in reception, letters to patients and telephone calls. Travel vaccinations were also available. There was a clear policy for following up non-attenders.

Good

Are services effective?

(for example, treatment is effective)

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about support services, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included Chlamydia screening for 16-24 year olds, advising patients on the effects of their life choices on their health and well-being.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients and their relatives and carers to organisations such as the Alzheimer's society and Help the Aged.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National Patient GP survey and a survey of patients undertaken by the practice. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey sent 252 surveys to patients, there had been a 52% response rate. Results showed the practice was rated highly at 89% for patients who rated the practice as good or very good in comparison to the CCG average of 87%. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at listening to them, 98% saying the nurse was good at listening to them, 92% saying the GP gave them enough time and with 97% saying the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and they were all very positive about the service experienced. Patients said they felt the practice offered a very professional service and staff were caring, efficient, friendly and professional. They said staff treated them with dignity and respect. We also spoke with patients on the day of our inspection. All the patients' we spoke with told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

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

Care planning and involvement in decisions about care and treatment

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

The results from the 2014 National Patient GP survey which we reviewed showed that patients' responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, 88% of practice respondents said the GP was good at explaining treatment and results and 83% that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that the GPs were caring, took their concerns seriously and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards we received was also overwhelmingly positive and each of the patients we spoke with told us that they were happy with their involvement in their care and treatment.

Staff told us that the vast majority of patients registered with the practice were English speaking. They told us that translation services would be made available for patients

who did not have English as a first language. An electronic appointment check-in system was available to reflect the most common languages in the area. Staff had access to an interpretation and translation service.

Patient/carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved. For example, there was a book and a board in the private, staff area of the practice that alerted staff to the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

Furthermore, relatives of patients who had died were called by the practice and offered a visit by one of the GPs, the purpose of which was to assess their emotional and support needs and to offer a referral to local counselling or bereavement support services. Patients were referred directly to these services by the GPs.

As we have reported above, patients who were identified as carers were provided with information about a local carer support service and referrals to this service were actively managed by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice utilised an electronic medical records system to record and collect information regarding patients. This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care, children who were known to be at risk of harm or those patients who were caring for others. The practices used a central booking system for making referrals to secondary care which gave patients a choice of location for their appointments. The practice had clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living.

The GPs at the practice had developed their own in-house specialism such as mental health and dementia, medicines management, minor surgery many of which were of benefit to the wider community as well as the patients registered at the practice.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example promoting integrated care amongst health and social care professionals within the area to ensure coordinated care for patients; including the patients at risk of falls and for people with mental health needs. One GP partner attended local CCG meetings. We were told their involvement in these meetings enabled informed service improvement for patients. Examples given included optimisation of prescribing and the introduction of local unplanned admissions avoidance schemes.

The practice had been particularly active in identifying those patients who were at risk of unplanned admission to hospital and who had tailored, individual care plans. The patients in this group were recorded on a register and the practice had a system in place for their care plans to be managed during monthly multi-disciplinary team (MDT) meetings. This enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including access to same-day appointments and clinical consultations on the telephone.

Patients we spoke with on the day of our visit said they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this prevailing view of the responsiveness of the practice.

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living, smoking cessation clinics and encouraging patients to utilise the practice self-monitoring blood pressure machine. The practice website included a number of links containing extensive information about the promotion of health for conditions which affect older people.

A GP had been the named GP for special needs schools in the area and clinical staff had been trained to take blood from children to avoid them having to go to hospital. The practice provided a service to a local care home. The practice carried out home visits and ward rounds to meet the needs of patients living there.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of patients living with dementia. Such patients received an enhanced service where they were recalled for an annual, face-to-face health

Good

Are services responsive to people's needs?

(for example, to feedback?)

review. Moreover, we saw that the practice ran regular checks of the data on their patient record system to identify patients with a range of factors that were particular indications of a learning disability or of dementia so that they could benefit from this service.

We also saw that the premises were configured in a way that enabled patients in wheelchairs to access their GP. There was level access throughout with widened doorways and an accessible toilet.

We saw that the practice web-site had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information about the practice and about NHS primary medical care. We saw that interpreters were arranged in advance and that extended appointments were booked to facilitate this on the infrequent occasions this occurred.

Patients who were short term visitors to the area, such as members of the travelling community, could access care where this was immediately necessary and by registering as a temporary resident.

Access to the service

Appointments were available daily from Orchard Surgery between Monday and Friday: 8.30am – 6.00pm with evening appointments available Wednesday evenings. These were pre-bookable appointments designed to be used by patients going to work. Patients could also register to book appointments, request repeat prescriptions and view their patient records online.

Priority was given to patients with emergencies and to children. Some appointment times were blocked off for this purpose. They were seen on the same day wherever possible. Patients we spoke with on the day told us that they had been able to get appointments for themselves, their family members or their children when required.

Patients could select their GP of choice if they were available. Chaperones were readily available for patients to use on request and the practice offered a text appointment reminder service.

The practice nurses ran separate clinics for people with long term conditions such as asthma, diabetes and hypertension. There were health promotion appointments available at the practice, such as for intrauterine coil insertion or removal. Signs were available in the reception and waiting room area that explained the appointment system. It also explained how to obtain emergency out of hour's advice through the 111 system. The practice had a dedicated telephone line for emergencies.

Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a double appointment where necessary to ensure all healthcare needs could be adequately discussed.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system.

The practice provided access for the local midwife clinic each week, we were told this was due to be extended to a fortnightly follow up clinic of one hour appointments to provide further care and support to patients during pregnancy.

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

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and

Good

Are services responsive to people's needs?

(for example, to feedback?)

allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had trialled opening the surgery on Easter Saturday to provide patients with an alternative to visiting the A&E department. The practice manager told us this had been a great success with patients; however the practice was waiting to hear of any improved impact from the local A&E department.

Listening and learning from concerns and complaints

The Care Quality Commissions inspection conducted on 4 September 2014, found staff were not clear who was responsible for handling complaints at the practice. Staff told us they would refer any problems to the person's GP. Records of complaints were held by each GP rather than centrally so trends and patterns could not be monitored. In addition we found the website did not contain clear information around who the complainant should contact.

In response to this the practice had reviewed its systems for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. There was a designated responsible person who handled all complaints in the practice. We found that all the staff we spoke with were aware of the complaints procedure, the responsible person and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception, on the practice website and the procedure was published in the practice leaflet. There was clear information on the practice website regarding complaints and who the complainant should contact. We saw that complaints recorded in the last eight months had been dealt with in a timely manner. A summary of each complaint included, details of the investigation, the person responsible for the investigation, whether or not the complaint was upheld, and the actions and responses made. We looked at the most recent complaints the practice had investigated. We saw that these had all been thoroughly investigated and the patient had been communicated with throughout the process. The practice was open about anything they could have done better, and there was a system in place to ensure learning as a result of complaints received was disseminated to staff. The process included an apology when appropriate and whether learning opportunities had been identified. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

Patients we spoke with had not had any cause for complaint, but told us they were confident that any issues they raised with the practice would be listened to and any appropriate actions taken.

We saw that complaints and significant events information was available and updated for all staff to review and discuss. The practice also provided compliments and concerns logs in the reception/administration area for staff to record all compliments and concerns, including verbal comments from patients and other services. Staff told us this was reviewed by the practice manager and enabled the practice to identify common themes and trends.

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

We found the practice had a clear clinical management strategy with all GPs participating in continuing professional development and this included online modules. The staff had mandatory directed learning and attendance at courses for example child safeguarding. Each morning the practice had a scheduled break for all staff, which provided opportunities for discussion of individual cases in a safe environment, where the clinicians and all staff could share safe and best practice.

The staff placed high value on being a family orientated practice, staff stability, understanding the needs of patients and continuity of care. We were told and saw there was a supportive and friendly culture among the staff. Staff also noted there had been a greater emphasis on improving the service following the Care Quality Commissions inspection conducted on 4 September 2014. Each staff member we spoke with were clear that they treated patients with respect, they listened to their concerns and they respected patient privacy and dignity.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available for staff to read. We viewed several of these policies and found that they had been reviewed annually and were up to date. Policies included infection control, chaperones, whistleblowing, complaints and comments and safeguarding. The practice manager had implemented a 'practice policy of the week' schedule. Each week a paper copy of a practice policy was placed in the staff room, staff were asked to take the time to read the policy and sign a cover sheet to confirm they had completed this. Staff told us this had been a useful way of refreshing staff knowledge and ensuring staff were regularly updated with practice policies and updates.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. This is an annual incentive programme designed to reward good practice. The QOF data for this practice showed it was performing in line with local CCG and national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. Team meetings were used to discuss issues and improve practises. We looked at minutes from the last two team meetings and found that performance, quality and risks had been discussed.

The practice had a programme of clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken and drive improvements. These included QOF performance, infection control, mortality rates and prescribing.

Orchard surgery took part in teaching junior doctors, known as foundation year doctors. These are qualified doctors at the beginning of their career who work under the close supervision of one of the senior GPs and learn about working in the teams that deliver care in the NHS as well as the clinical aspects of caring for sick patients. In addition the practice was involved in teaching medical students.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, including health and safety and fire risk assessments. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example risks identified from significant events, patients comments and complaints. These were clearly identified and reviewed on a regular basis to ensure that patients and staff were safe.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of putting patients first. The partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy

Are services well-led?

Good

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

existed for all staff to raise issues whenever they wished. Staff told us and we saw that all staff were encouraged to contribute their views and to have some ownership of the delivery of the practice vision.

Decision making and communication across the workforce was structured around key, scheduled meetings. Practice clinical meetings took place monthly, where significant event analysis, QOF data, audits and clinical issues were discussed. Multidisciplinary team meetings took place monthly; these meetings were attended by GPs, practice nurses, community nursing teams including community matrons, physiotherapists' occupational therapists and the palliative care team. In addition the practice met monthly with health visitors and local school nurses to discuss safeguarding. The practice manager told us staff meetings were held as and when they were required. However we saw from the meeting minutes that complaints and significant events were discussed with staff at meetings, via the two logs available for staff and staff were briefed about any changes as and when they occurred through informal briefings and emails. Staff told us that they would find it beneficial to be able to access meeting minutes from their computers.

In addition to staff meetings, the practice featured a daily, informal coffee meeting that took place for a short time each morning. All available medical, nursing and administrative, reception and dispensing staff attended. Any incidents and concerns arising from the morning's work were discussed and dealt with immediately or escalated for further investigation or more detailed discussion and consideration in a more thorough formal meeting.

We spoke with staff about this approach and they told us they felt valued and able to contribute. The practice manager explained that there was a low turnover of staff in all roles. We noted that staff were positive in their attitudes and presented as a happy workforce. We considered this to be evidence of the effectiveness of the open and candid approach adopted by the practice.

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

The practice encouraged and valued feedback from patients and was in process of recruiting to a virtual group. A patient representation group (PRG) are a group of patients who work with the practice staff to represent the interests and views of patients, to improve the service provided to them. A virtual group liaises with the practice via email.

The practice gathered feedback from patients through practice surveys, compliments and complaints received. The practice monitored feedback from patients in other ways such as the compliments and comments books in reception, a comments box, review of the national patient survey and the Friends and Family Test. (this is a tool that provides patients with the opportunity to feedback on their experiences of a service, with the intention that it will stimulate improvement across the NHS). We saw the practice ran an on-going patient survey throughout the year and encouraged patients to participate. Access to the survey was available on the practice website and in the practice waiting room. The practice manager told us the results of the surveys were collated and reviewed by the PRG and results were published in the practice and on the practice website.

We saw that the practice had produced action plans from the findings of the 2012/2013 and 2014/2015 patient surveys in order to address shortcomings; these were published on the practice website. We noted that patient and PRG patient comments from the surveys were also published on the practice website. We noted that actions taken form the action plan were on-going or had been completed. For example development of the practice website, other actions were on-going or under review such as on-line appointment bookings and cancellations. On-line appointment bookings were available on the website; however the practice were in the process of developing on-line appointment cancellations.

Staff told us the practice open door policy meant that they felt able to make suggestions. For example the referral spread sheet developed by a medical secretary had been developed and was being adapted for other monitoring purposes.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain

Are services well-led?

Good

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

its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning through protected learning time.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. All patient referrals were peer reviewed by another GP to ensure they were appropriate and that alternate pathways had had been considered by the original GP. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working. It was clear to us that everyone who worked at the practice found the daily informal coffee meetings to be of great benefit. This showed that the practice had a dynamic and responsive approach to seeking opportunities to learn and improve.