Dr AD Pullan & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr AD Pullan and Partners on 25 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive services and for being well-led. The practice was found to be good for the services it provided to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses.
- GPs worked with patients and their families and carers to ensure that they understood how treatments could support their health and that they received the most appropriate care for their needs.
- Patients told us that the staff were caring, compassionate and respectful towards them. Information showed that GPs and nursing staff were good at listening to patients.
- The practice proactively sought feedback from patients and staff. Access to services and changes to the environment and the way it delivered services were made as a result of feedback received by the practice.
- The practice had a clear vision and values which were shared with its patients and staff. Staff felt supported by the leadership in place.

There were some areas of practice where the provider needs to make improvements.

In particular the provider should:

- Ensure that systems in place clearly demonstrate an audit trail of how lessons learned and plans for improvement from significant events/incidents, and near misses are disseminated to staff.
- Ensure that meetings are minuted to clearly show what was discussed, action to be taken, by whom and when.

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- Ensure that staff are aware of the process they should follow if safeguarding concerns are identified.
- Ensure that blank prescriptions are stored securely at all times
- Ensure that risk assessments are completed on all staff considered to not need criminal records checks via the Disclosure and Barring Service
- Ensure that confidential patient information is not being inadvertently insecurely stored in the cluttered consulting room.
- Consider providing an alarm call in the disabled toilet.
- Consider providing baby changing facilities.

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. There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable patients who used the service. There was regular monitoring of safety to ensure that ways to improve were identified and implemented. Patients who used the service told us that they felt safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. A clear and structured approach to meetings was needed to clearly show that lessons learned from significant events/incidents, near misses, complaints and safeguarding concerns were disseminated to staff. We found that not all staff knew who the safeguarding lead was. Risk management was comprehensive and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both NICE and other locally agreed guidance. We saw evidence that patient's needs were assessed and care was planned and delivered in line with current legislation. We saw data that showed that the practice was performing at or above average in some areas when compared with other practices at the CCG. We saw that the practice was proactive in addressing areas of under performance. This included assessing and promoting good health. The employment of an additional practice nurse supported the enhanced initiative to develop care plans for all identified at risk patients. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice had completed appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care was positive. Data showed that patients rated the practice at or above average than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

Summary of findings

about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff on the whole treated patients with kindness and respect, and were aware of the importance of maintaining confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG), patients and staff. The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Patients identified problems with accessing appointments. For example, patients told us that they could get an appointment with a named GP or a GP of their choice, if they were prepared to wait up to two weeks. Patients were aware that the practice continuously reviewed the appointment system to ensure improvements to access for patients. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded when issues were raised.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular governance meetings. We noted that the practice needed to ensure that agendas and minutes were recorded for meetings to clearly show what was discussed, action to be taken, by whom and when. The practice needed to ensure that confidential patient information is not being inadvertently insecurely stored in the cluttered consulting room. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. There was evidence that the practice had a culture of learning, development and improvement. The practice had a clear vision and strategy to improve the services they provided. Staff told us that the practice had an open and supportive leadership and were clear about the vision and their responsibilities in relation to this.

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's 'avoiding unplanned admissions' list to alert the team to people who may be vulnerable. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its flu vaccination programme. The practice nurse planned to provide these for patients in their own homes if their health prevented them from attending the clinics at the surgery. The practice worked with two local care homes to provide a responsive service to the patients who lived there. The practice offered older people the opportunity to have tests and investigations such as blood and urine tests carried out at the time of their appointment. This prevented them having to come back to the surgery or attend hospital for the tests. The practice provided older patients with the opportunity to have blood and urine tests carried out at the time of their appointment. This reduced the need for a referral, repeat visit or to have to travel to another service.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions, for example asthma and diabetes. All of 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. This included working with a multidisciplinary team of professionals to provide support to patients with long term medical conditions. The Flo Telehealth System was used to involve patients with long term conditions in the management of their care. The system motivates patients to take more responsibility for their own health by allowing them to monitor their own condition and receive information or guidance by text.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice often provided care and treatment to whole families. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

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Families were welcomed to attend consultations together if appropriate. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Six week postnatal and neonatal checks were carried out at the practice. The practice provided a family planning service. Suitable toys were available for children in a play area within the waiting room.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of this population group 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 reflected the needs of this age group. Extended opening times and telephone consultations were offered to patients who were unable to visit the practice during the day.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, people who misused drugs and alcohol and those with a learning disability. The practice had carried out annual health checks for patients registered with them whose circumstances made them vulnerable. This included patients with a learning disability who were offered longer appointments if needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. This included the local Learning Disability Enhanced Service. The practice had informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the local mental health team which worked with the practice to identify patients' needs and to provide patients with counselling, support and information. The practice also worked with other local community mental health services. Care plans were in place for all patients with dementia. We were told copies of these plans were also held in patients' homes. The Flo Telehealth System was used to support the care of people with dementia. The system motivates patients to take more responsibility for their own health by allowing them to monitor their own condition and receive information or guidance by text.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection; these patients were willing to share their experiences with the expert by experience. We spoke with and received comments from patients who had been with the practice for many years and patients who had recently joined the practice. Patients we spoke with at the inspection were extremely positive about the service they received. They told us that they were respected, well cared for and treated with compassion. Patient's described the staff and GPs as excellent and told us that they were listened to by all staff.

We reviewed the 27 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments made were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and approachable. They said the staff listened and responded to their needs. Patients also commented on areas they would like to see improvements. Patients told us that they had problems making appointments over the telephone and could not always see a GP of their choice. Some patients told us that they were aware that the practice was looking at the appointment system and had noted some improvements.

We looked at the results of the last national GP Patient Survey published in 2014. The survey found that 81% of patients described their overall experience of the practice as good or very good; this was just below the local Clinical Commissioning Group (CCG) average. Further information showed that 73% of patients would recommend the practice to someone new to the area, which was also lower than the local Clinical Commissioning Group average. A survey was carried out by an external organisation which allowed the results to be compared nationally. Results showed that patient's experiences scored highly when compared to other practices. For example 88% of respondents said the practice was good, very good or excellent and 90% said that they were shown respect. The results also showed that improvements had been made on their previous year's results. The worst experience for patients that scored below the national average was telephone access. The practice had developed an action plan to address this.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that systems in place clearly demonstrate an audit trail of how lessons learned and plans for improvement from significant events/incidents, and near misses are disseminated to staff.
- Ensure that meetings are minuted to clearly show what was discussed, action to be taken, by whom and when.
- Ensure that staff are aware of the process they should follow if safeguarding concerns are identified.
- Ensure that blank prescriptions are stored securely at all times
- Ensure that risk assessments are completed on all staff considered to not need criminal records checks via the Disclosure and Barring Service
- Ensure that confidential patient information is not being insecurely stored in consulting rooms.
- Consider providing an alarm call in the disabled toilet.
- Consider providing baby changing facilities.

Dr AD Pullan & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included two specialist advisors a GP and a practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Dr AD Pullan & Partners

Dr AD Pullan & Partners practice (Furlong Medical Centre) is a well established GP surgery that was purpose built in 1995. The practice provides primary medical services to patients living in Stoke On Trent, Staffordshire, covering mainly the Tunstall area of Stoke On Trent. The practice treats patients of all ages. The highest percentage of its practice population is in the under 65 age group. The practice is located within an area of high deprivation and unemployment. The medical centre is owned by the practice. The building consists of 13 consulting rooms. All clinical rooms and treatment rooms are located on the ground floor. The premises have been modernised over time with special consideration for the disabled, including parking and some internal adaptations to ensure easy access.

The practice has six GP Partners and two GP Registrars (four male and two female), a practice manager, six practice nurses (two of the practice nurses share the role of lead nurse), two healthcare assistants, reception, administrative and secretarial staff. The staff provides a service to 10103 patients registered with the practice. The practice serves the local population by providing general medical services. Services provided include the following clinics; contraception and sexual health, asthma, diabetes and a drop in clinic for lifestyle checks and advice for example smoking.

Furlong Medical Centre is an approved GP training practice for Registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine). The practice is also an accredited teaching and training practice for medical students and newly qualified doctors who are in year two of 'The Foundation Programme (FY2). The Foundation Programme is a two-year training programme for doctors after leaving medical school. It is designed to give trainees a range of general experience and enable them to take on supervised responsibility for patient care as a professional in the workplace, before choosing an area of medicine in which to specialise.

The practice has a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. A GMS contract is a contract between General Practices and NHS England for delivering primary care services to local communities. As part of this contract, quality and performance is monitored using the Quality and Outcomes Framework (QOF).

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

Detailed findings

The practice is not a dispensing practice; patients obtain their prescribed medicines from their local chemists. The practice does not provide an out of hour's service to their own patients. They have alternative arrangements in place for their patients to be seen when the practice is closed.

Why we carried out this inspection

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

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS England, East Staffordshire CCG and the local Healthwatch to tell us what they knew about Dr AD Pullan & Partners Surgery and the services they provided. We reviewed information we received from the practice prior to the inspection. The information we received did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 25 November 2014. During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, healthcare assistants and reception and administration staff. We spoke with nine patients and members of the patient participation group (PPG) who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed surveys and comment cards where patients shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we reviewed a complaint where a patient had been refused a repeat prescription and saw how this had been dealt with in a timely way.

We saw documents that detailed reported incidents and suggestions and complaints received from patients. These were reviewed and discussed at annual meetings. The meetings were attended by the GPs and practice manager. The practice produced a report which identified what action had been taken, what lessons were learned and how risks were to be managed. The minutes contained a note which stated that all clinical complaints and suggestions had been dealt with, or were currently being dealt with separately with the individual concerned. Staff told us that complaints and incidents were discussed with them. We found that there was a lack of information to confirm and evidence the discussions that had taken place with other staff before the annual meeting. For example, structured agendas and minutes of meetings to clearly demonstrate what had been discussed, the outcome of the meetings, action to be taken, by whom and when and the learning shared with staff.

We reviewed the annual review of significant events. This showed that seven significant events had occurred over the last 12 months. These included an example where reception staff had failed to book a patient in for their appointment which resulted in the patient waiting in the surgery for over an hour. The mistake was rectified by the practice who made sure the patient was seen by a GP. The practice took steps to prevent a similar error happening again by displaying a poster informing patients to let the receptionist know if they have been waiting for longer than 30 minutes. Information we read showed that the practice had completed a review two months later to ensure that this type of incident had not been repeated.

An area where a risk had been identified was as a result of a complaint. A patient had been wrongly advised that staff at the practice did not remove staples/clips from wounds. This resulted in the wound becoming infected by the time the patient was seen at a health centre. We saw that measures had been put in place to prevent this happening again. For example, the practice nurses had undertaken training with reception staff to ensure they were aware of the type of wound and dressing procedures they carried out. Notices providing guidance and a reminder for reception staff were also displayed in the reception and phone room.

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 over the last twelve months and we reviewed these. There was evidence that the practice had learned from these, for example, the results of a patient's blood test showed that they were urgent, however the results were not reviewed or shared with the patient for two days. This was identified and actioned on the second day. The annual report we read showed the action taken was to notify all staff of the procedure to be followed when urgent results are received. A review was undertaken one month later to ensure that the event had not occurred again. The outcome of this was not stated. The practice would continue to monitor that staff were following the policy.

The annual report detailed seven incidents that had occurred within the last 12 months. The report did not contain sufficient information to confirm that the incidents were addressed and completed in a comprehensive and timely manner. However the report included details of the action taken to address the significant event for example, a letter received about a patient following discharge from hospital contained inaccurate information. The practice raised this with the hospital concerned. The hospital apologised and amended the letter to ensure it contained the correct patient information.

We saw that a system was in place to disseminate national patient safety alerts to practice staff. The alerts were reviewed by one of the GPs. The GP disseminated these if relevant to staff via the deputy practice manager. The alerts were also discussed at the practice meeting if appropriate.

Reliable safety systems and processes including safeguarding

Good

Are services safe?

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

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the highest level of training to enable them to fulfil this role. All other staff had been trained to a level which enabled them to recognise signs of potential abuse. We were told that safeguarding meetings were held both at the practice and externally to ensure that all interested parties were aware of the concerns. However we also found that one of the GPs and one of the practice nurse's did not know who the safeguarding lead was. Other staff showed confusion and mentioned two different names. A further GP was also unsure of where the safeguarding policy was kept. Accessible information on the process staff should follow in the event of safeguarding concerns were not available in all consulting and treatment rooms. We discussed this with the practice as we could not be sure that all staff would follow appropriate internal and external procedures in the event of a safeguarding concern.

Records were kept on an electronic system known as System One. The system collated all communications about the patient including scanned copies of communications from hospitals. This included information so staff were aware of any relevant issues when patients attended appointments. The system also highlighted vulnerable older patients on the practice register. This included information to make staff aware of any relevant issues when patients attended appointments; for example patients with a learning disability, for which the practice held a register of 54 patients. An alert also appeared when staff accessed the records of children subject to child protection plans or for the follow up of children who persistently failed to attend appointments, such as for childhood immunisations. System One had recently been implemented at the practice. Staff had received training and were becoming familiar with the system.

We saw that there was a chaperone policy in place which followed national guidance. A chaperone may provide reassurance to patients or support best practice when a male examiner carries out an intimate examination on a female patient. We found that posters or other information was not available to patients in the waiting room. We discussed this with the senior nurse and the practice manager. Both agreed that patients may be better prepared to make a decision about a chaperone if they were aware that this service was available to them before their consultation. The practice nurses confirmed that they provided a chaperone service for patients whenever this was required.

We were shown systems in place for the identification and follow up of children, young people and families living in disadvantaged circumstances. Clinical staff were alerted to children who persistently failed to attend appointments, such as for childhood immunisations. This information was also shared with health visitors who carried out clinics at the practice. The patient information system also alerted clinical staff to patients with multiple medications who needed to be reviewed before a repeat prescription was issued.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The policy described the action staff should take in the event of a power failure and the refrigerators failed to work.

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.

We saw there were Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw

the PGDs had been signed by all the nurses who administered the vaccines and authorised by a GP. This meant that staff, GPs and managers were informed of any changes to PGDs.

The lead nurse was a nurse prescriber. They had completed a specialist course and attended a medicine management workshop annually. The lead nurse told us that they were due to attend an antibiotic prescribing workshop in November 2014.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We found that blank prescription pads were not completely handled in accordance with national guidance. We found that not all prescription pads were securely stored. For example we saw a prescription pad in the practice managers office and GP bags. Action to remedy this was taken at the time of the inspection. We were assured by the practice that they would review their security procedures to ensure prescription pads were stored securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw that hand gel was available in the waiting room for patients to use. We saw records that confirmed that the testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings) had been carried out.

One of the lead nurses was the lead for infection control. The practice nurse 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 received annual updates. We saw evidence that the lead had carried out infection control audits.

The practice carried out regular infection control risk assessments. 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 and aprons were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy.

We saw records that confirmed the practice was carrying out regular checks in line with their policies to reduce the risk of infection to staff and patients. Staff were checked for their immunisation status as part of the practices' pre-employment health assessment process. This was a preventative measure to protect staff from the risk of infection while undertaking their role. The infection control policy also included information on how to deal with needle stick injury and bodily fluid spills. There were procedures in place for the safe disposal of sharps and clinical waste.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment which enabled 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, October 2013. This was confirmed by the records held by the practice. We saw a schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales.

Staffing and recruitment

We saw that the practice had a robust recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at two staff records these contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, a full work history, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had made a decision not to undertake criminal records checks on reception and administration that had worked at the practice for a long-term. We were told that this was mainly because this group of staff were not involved in providing care or treatment directly to patients for example, they were not involved in chaperoning patients. However risk assessments had not been completed to show that there was a low level of risk from these staff members. The practice had made the decision that future newly appointed staff would have this check carried out.

Good

Are services safe?

The practice had confirmed that the medical students seconded to the practice had undergone checks to ensure they were fit to work with vulnerable people and children by their university. There were systems in place to check that clinical staff registrations with their professional bodies were in date.

The practice employed sufficient and suitable staff to meet the needs of their patients. We saw that the practice was proactive in reviewing and amending its staffing skills and levels. Staff told us there was usually enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe. Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw that there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty.

There was also an arrangement in place for members of staff, including GPs, nursing and administrative staff to cover each other's annual leave and sickness where possible. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Patients we spoke with told us that they had not experienced any problems with getting an appointment with a GP or practice nurse.

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

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: there were emergency processes in place for patients with long-term conditions, acutely ill children and patients in mental health crisis. We observed that these procedures were followed when a GP dealt with an emergency involving one of their patients.

We noted a potential risk at the time of our inspection. We found that one of the radiators in the waiting area was hot to touch and that children were playing in this area. We discussed this with the practice manager. Action to remedy this was taken at the time was and we were reassured that appropriate long term action would be taken.

Arrangements to deal with emergencies and major incidents

We looked at the business continuity plan for the practice. At the time of our inspection we saw that this was not put together as one document. Which made it difficult to access. Following the inspection the practice manager reviewed the plan and forwarded a copy of the complete document to us. We found that the business continuity plan identified key risks, including potential damage to the building; the loss of power and the loss of computer systems. Staff were aware and directed by the practice manager on the action to be taken to manage the various changes. There was a list of key contact numbers including utility suppliers. Information we read provided clear guidance for staff to follow in the event of an emergency.

The practice had arrangements in place to manage emergencies. We were told that all members of the practice team received annual training in basic life support. This was confirmed by the staff we spoke with and training records we reviewed. The practice nurse told us they had also completed training in managing patients who had severe reactions to allergens (anaphylaxis).

Emergency medicines were checked and monitored to ensure they were within their expiry date and suitable for use. Emergency medicines were kept in a box in a cupboard within a room off the reception area. We checked the medicines and found that they were appropriate for a range of emergencies and were in date. However we noted that the medicines were not safely stored because they were stored in an unlocked cupboard and the door to the room was not locked. We discussed this with the practice management team and appropriate action was taken.

Emergency equipment was accessible at a central point in the surgery. The equipment was monitored to ensure that it was appropriately tested and maintained. The GPs checked their own bags to ensure its contents were fit for use.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidelines for prescribing a specific antibiotic (Co-amoxiclav) was disseminated to the GPs at a practice meeting. We saw evidence that through an audit the implications for the practice's performance and patients were discussed and required actions agreed. 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.

The GPs told us they led in specialist clinical areas such as mental health, dermatology, diabetes and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The GP partners were responsible for the majority of lead roles. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Staff were supported to continually review and discuss best practice guidelines. An example included the management of patients who received medication to modify and/or control their cholesterol levels. We were shown an audit with action to be taken and prescribing guidelines for GPs.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital and saw that these patients were regularly reviewed. Unplanned admissions were discussed at fortnightly practice meetings.

National data showed that the practice was above average for referral rates to secondary and other community care services for some conditions. The rates for patients who attended accident and emergency were above the national average when compared to other practices within the Clinical Commissioning Group (CCG). We saw that the practice had developed a quality improvement plan to address the CCG standards where the practice was not performing well and that improvements had been made. Information we read showed that the CCG had acknowledged and commended the practice on these improvements

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. GP trainees and medical students were included in this process.

The practice had a system in place for completing clinical audit cycles. The practice showed us seven clinical audits that had been undertaken over a number of years. We saw that some audits were linked to recent research for example, the practice carried out a review of their patients with cardiac disease who had been prescribed Diclofenac (pain control medicine). Audits had repeated clinical cycles or planned dates to reassess ongoing improvement. The outcome of audits were used as a learning tool. Other audits we looked at related to the operation of the practice. For example, an audit to assess appointment availability for patients had been completed. Following the audit the number of appointments offered by the GPs and nurses were reviewed.

The practice had completed clinical audits related to minor surgery and therapeutic injections. The minor surgery audit looked at post-operative wound infection following procedures carried out the practice. The outcome of the audit did not raise concerns for the practice. They found that of the 30 patients a small number (3.3%) showed signs of possible infection and required a topical antibiotic medicine. The audit was completed in November 2014 and would be completed again in 6 months.

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

Good

Are services effective?

(for example, treatment is effective)

and QIF a local performance measurement tool. The practice used the information collected for the performance tools to monitor outcomes for patients. Performance data from the local clinical commissioning group (CCG) showed for example that the practice was underperforming in ensuring patients aged 65 years and over received the flu vaccination. The practice had put a plan in place to address this. Action identified to be taken included determining reasons for the poor uptake through discussions with the PPG and nurses, ensure easy access and introduce Saturday vaccination clinics.

The team made use of clinical supervision, appraisals and staff meetings to assess the performance of clinical staff. GPs held fortnightly practice meetings which were attended by the practice managers and senior practice nurse. Other regular meetings were held these included clinical meetings and significant event meetings. The different groups of staff held individual team meetings every month. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where improvements could be made. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice information technology (IT) system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question. Where the GPs continued to prescribe the medicine they outlined the reason why this decision had been made. The practice also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Patients we spoke with confirmed that their medicines were regularly reviewed.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had some outcomes that were above or just below average when compared to other services in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example in relation to child immunisations.

The practice maintained a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families; it involved patients in making decisions about their care and treatment for as long as possible.

Effective staffing

Effective staffing at the practice commenced with a formal interview followed by a formal planned induction if appointed. All clinical staff had annual appraisals which identified their learning and training needs and personal development plans. The practice used a 360 Degree appraisal Feedback system. This is a system in which employees receive confidential, anonymous feedback from the people who work with them. Any issues of poor performance were addressed by agreement with the practice manager, lead GP and lead nurse where appropriate.

All staff were happy with the training opportunities offered to them by the practice. The practice was proactive in providing training and funding for staff in relevant courses to ensure they were competent in their role. We looked at training records which confirmed that all staff had received training in health and safety, fire safety, equality and diversity, basic life support, information governance and safeguarding.

We found that the process of revalidation for GPs was on going and some had already been revalidated or had a date for revalidation. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) on a regular basis that they are fit to practise and their knowledge is up to date. (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). Nursing staff had received training specific to their role for example, family planning, travel health, ear syringing, vaccinations and immunisations.

Good

Are services effective?

(for example, treatment is effective)

The practice checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register to make sure that they were remained fit to practice.

Working with colleagues and other services

The practice worked with other service providers to meet people's 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. We saw that all letters related to patients were scanned so that they were available.

The practice held multidisciplinary team meetings three monthly to discuss the needs of complex patients including those with end of life care needs or children on the at risk register. These meetings were attended by a GP, practice nurse, community matron, district nurses and a children's nurse. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and saw the meetings as a means of sharing important information. However minutes we reviewed contained no names or timescales for action to be taken.

At one of the practice meetings held in April 2014, the practice manager had suggested that it would be beneficial to the practice for him to spend time working with a practice manager at another practice. This would be a selected practice that was operating effectively and therefore the practice could learn from them. The experience would be useful to the practice going forward and also support the practice manager's own personal development.

We saw that the practice worked with midwives to assist in the provision of antenatal care to pregnant women and health visitors to support the care of babies and young children. The practice worked with the local primary care mental health team to provide appointments at the practice for patients experiencing poor mental health.

Information sharing

A confidentiality agreement was in place to manage access to, and the use of patient identifiable information and where appropriate the transfer of that information to others. A confidentiality policy had been written and approved by the practice. Staff were asked to sign the agreement to confirm that they had read, understood and agreed with it.

The practice used an electronic patient record system to document and manage patients' care. All staff were trained to use the system. The system enabled scanned paper communications, such as those from hospital, to be saved to patient records. We saw that the GPs reviewed all information which was added to patient records. The practice used their system 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 efficient manner.

Patients were encouraged to sign up to the electronic Summary Care Record. This record would provide health care staff treating patients in an emergency or out of hours with faster access to key clinical information. Patients had access to information about the Summary Care Records on the practice website and in posters at the practice. Patients were also made aware that they could choose to opt out of signing up to these if they wished to.

Consent to care and treatment

There were systems in place to seek record and review consent decisions. For example, for all minor surgical procedures and intimate examinations, a patient's verbal consent was documented in the electronic patient record. For some procedures, including minor surgery and therapeutic injections, written consent was obtained. We saw a form that patients signed to acknowledge that the procedure, the benefits and risks had been explained to them before they gave their consent. We saw that patients had signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

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 to. The plans

Good

Are services effective?

(for example, treatment is effective)

included details of the patient's preferences for treatment and decisions. Staff at the practice told us copies of the care plans, which included patients with dementia, were kept in their homes.

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 help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

It was practice policy to offer a health check 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. For example, by offering smoking cessation advice to patients who smoked and dietary advice to patients who presented as being overweight.

The practice offered NHS Health Checks to all its patients aged between 40 – 74 years who were not already diagnosed with diabetes, heart disease, and stroke or kidney disease. These checks included a cholesterol test, blood pressure check, weight and lifestyle management advice. We saw notices in the waiting room that made patients aware that these health checks were available.

The practice provided flu vaccinations to vulnerable groups and shingles vaccinations to the groups of patients specified in NHS guidance. Travel vaccinations were available for patients who requested them. The practice offered a full range of immunisations for children in line with the Healthy Child Programme. GPs cared for patients who were pregnant in partnership with local midwives. A health visitor held baby clinics at the surgery. There was a clear policy for following up patients, mothers, babies and young children who did not attend these clinics. Their performance for all immunisations was above or just below the average for the CCG. The practice had a clear policy for following up non-attenders by the practice nurses and admin staff. Posters and leaflets at the practice and information on the practice website made sure eligible patients were made aware of the vaccines available to them.

Family planning services were provided by the practice for women of working age. Cervical screening was offered to women. Patients who did not attend for cervical smears were offered various reminders, by telephone and letters for example and the practice audited non-attenders annually. The practice offered a free and confidential Chlamydia screening service for all 16 – 24 year olds. Free condoms were also available.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept registers of their patients who would be considered at risk and or vulnerable. The practice had identified 158 patients in this category. These included a register of patients with learning disabilities, and a register of all patients with mental health problems. These patients received an annual physical health check by the practice. The practice was in the process of completing the care plans for this group of patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with nine patients during the inspection. We spoke with women and men of different ages; parents of children; disabled patients and patients who were vulnerable because of a learning disability or mental illness. Patients on the whole spoke well of the staff. They said that staff were kind and considerate. However there were concerns about reception staff. They said that they were not always respectful. Patients told us that this was not all reception staff and most of the time they were treated with respect and dignity. Patients told us they trusted the GPs to provide them with the best possible care.

Twenty seven patients had completed comment cards for us. Their comments were all positive. These patients told us the practice was excellent and that staff were kind and courteous. No patient expressed any complaint about the practice. We saw that staff at the reception spoke with patients in a discrete manner. We did not overhear any private information. Patients confirmed that their right to privacy and confidentiality was respected. We saw that the practice had a leaflet for patients which included information about their right to privacy and how the practice maintained this through their systems and the behaviour of staff. We found that members of the practice team maintained confidentiality, by closing doors to consulting rooms and knocking doors before accessing rooms.

We observed how patients were treated by receptionists. We observed that reception staff were generally pleasant and welcoming to patients. However we observed an occasion where a patient whose first language was not English found it difficult to understand the receptionist. The receptionist did not handle the situation well and did not determine what language the patient spoke so that they could use the resources available to them. The patient's privacy and dignity was compromised as other patients tried to help. A second receptionist intervened and took the patient to a private booth. The patient was seen by the reception supervisor in private, who resolved the issue.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey which indicated that over 98% of patients described their overall experience of the practice as 'good' or 'very good'. We saw that 99% would recommend Dr AD Pullan & Partners to others, compared with a national average of 79% of patients who would recommend their GP practice.

We spoke with representatives of the Patient Participation Group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The PPG representatives were involved in discussing healthcare issues. The practice sent out an annual survey to patients. A survey was carried out in January 2014. The survey focussed on three specific areas; access to and the quality of out of hours services; the practice repeat prescription services and the care provided by the GPs and nurses. Responses showed that 72% of patients knew how to contact the out of hours GP services, 72% of patients felt the prescription service was very good and 87% of patients said that the nurses treated them with care and concern.

Care planning and involvement in decisions about care and treatment

The patients we spoke with and those who left comment cards for us expressed that they felt 'listened to' by the GPs and nurses. Patients told us they were actively involved in their treatment plans. They said that information was explained in ways they understood and that they were told about the choices available to them. For example patients described the range of care options available to meet their own or their family member's particular conditions and that they had reviewed the choices with the GP or nurse before arriving at a decision about proceeding with treatments.

Staff told us that patients were encouraged to take responsibility for their health and to be involved in decisions about their treatment. Patients spoken with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. To support and promote patient involvement in their care the practice had introduced the 'Flo' Telehealth System at the practice. The Flo system motivates patients to take more responsibility for their own health by allowing them to monitor their own condition and receive information or guidance. The system also

facilitates the sharing of information across appropriate healthcare teams. The Flo Telehealth System was used by the practice to promote and support the health of their patients for example, blood pressure monitoring, asthma and contraceptive reminders. The Flo system motivates patients to take more responsibility for their own health by allowing them to monitor their own condition and receive information or guidance.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 national patient survey showed 77% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining their treatment and results. Both these results were above the national average.

Patients were told how long it would be before their test results were received by the practice. Patients were made aware that it was their responsibility to check their results and make an appointment to discuss them with the doctor if advised to do so. Patients were told to call the practice between 11am and 12.30pm to enquire about test results. To ensure confidentiality patients were reminded that test results can only be released to the patient to whom they relate or someone who had been given prior permission in writing.

The practice had undertaken developing care plans as part of a national enhanced service initiative, for high risk patients and to avoid unnecessary hospital admissions. This included older patients, patients with long term conditions and patients with complex conditions. Patients care plans had been developed with the involvement of the carers family or carer as appropriate. To support this initiative the practice had employed an additional practice nurse whose main role was to assess and develop care plans with identified at risk patients. We were shown examples of the CCG local initiative scheme care plan templates for older people and patients with long term conditions for example, asthma.

Patient/carer support to cope emotionally with care and treatment

The 2014 national survey information showed that 81% of patients responded that the GPs treated them with care and concern and 70% responded positively to the same question asked about the nurses. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this survey information. For example, patients told us that staff responded compassionately when they needed help and provided support when required. Patients told us that they did not feel rushed during consultations and felt that they had enough time to discuss their problems.

Patients who had suffered a bereavement were referred to a local support group or other services depending upon their need. Notices and leaflets in the waiting room and on the practice website provided a wide range of information for patients and carers about how to access a number of local and national support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Staff told us that families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs.

Some patients we spoke with told us about difficulties they had experienced with their mental health. These patients told us about the care and support they had received at the practice over a long period of time. Some patients told us that their GP had sought to find appropriate additional support for them within the community. Other patients we spoke with who experienced mental health problems said that they had not been referred to other support agencies. These patients were happy with the support they received at 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 provided a service to people in vulnerable circumstances. This included patients who misuse substances and patients with mental health difficulties. Patients with mental health problems were referred within the practice to a GP who had a special interest in mental health. Patients were also referred to specialists within the community.

We found the practice was responsive to people's needs and this was confirmed by the nine patients we spoke with and the 27 patients who left comment cards for us. Patients said the care they received was personalised and that they always felt they were listened. Patients who had required a referral to other healthcare providers told us that the GPs were thorough in reviewing and advising them of the treatment options available to them.

The practice had developed its understanding of its patient population over time. There were systems in place to maintain the level of service needed. For example, the practice continuously reviewed the volume of appointments needed and ensured they had sufficient GP and practice nurse sessions to meet this. The importance of and need for home visits were also considered to ensure that patients received the care and support they needed.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. For example the practice was participating in an enhanced service to compile a register and complete care plans for patients considered to be at risk. This involved the practice demonstrating how they worked with other professionals.

The practice manager told us how the practice planned to implement suggestions for improvements and make changes to the way it delivered services in response to feedback from patients, staff and the patient participation group (PPG). For example, changes that had been made to the appointment system, which included providing, evening appointments for working patients, improved telephone access and improvements to the waiting room. The practice also responded to their patient's questions and feedback on their controlled Facebook site. The number of patients and others that had joined the practices' Facebook site was growing and had proved helpful in the support it offered to patients.

We saw that the practice had added a children's area where they could be occupied safely. Items provided included educational toys. These were easily cleaned in between clinics to prevent the risk of cross infection.

Tackling inequity and promoting equality

Training information showed that staff had completed equality and diversity training. Staff told us that all patients received the same quality of service from them to ensure their needs were met without discrimination. We saw evidence of this during the inspection where staff demonstrated a caring and supportive approach towards patients. Patients told us that that they were treated with sensitivity

The practice had recognised the needs of their different population groups in the planning of its services. For example staff told us that patients whose circumstances made them vulnerable such as homeless people and people experiencing problems with alcohol or drugs were able to register with the practice. As a result of listening to patients the practice had extended their appointment times to facilitate attendance for patients who could not attend appointments during normal surgery hours. This allowed flexible access for vulnerable population groups, working age people including those in full time education. Arrangements were in place to ensure that vulnerable groups such as patients with a learning disability, older people and people with mental health difficulties could have regular access to a GP as needed.

The practice was purpose built and had been adapted to meet the needs of people with disabilities. We saw that there was easy access to the practice. There was an easily accessible disabled toilet for patients. To support access for all patients there were a number of facilities to support them such as clear signage and an induction loop for patients who had a hearing impairment. We noted that there were other areas where improvements could be considered for example, some patients told us that the chairs were not all suitable. They said that chairs were to low and there were no arms on chairs to help when sitting and getting up. We noted that patients in wheelchairs did

Good

Are services responsive to people's needs?

(for example, to feedback?)

not find it easy to access the reception desk as there was not a lowered access area. We also noted that there was no emergency call bell system in the disabled toilet and mothers did not have access to baby changing facilities.

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

Access to the service

The practice was aware that they had a shortfall of GPs to meet the needs of the number of patients registered with them. The practice had reviewed this and put a plan in place to address the shortfall. The plan included GPs undertaking additional clinics and appointing a locum to cover an initial two month period; this could be extended if needed. On a permanent basis the practice was looking at recruiting a salaried GP.

The practice leaflet and website advertised their opening times as 8am to 6pm (Monday, Tuesday, Wednesday and Friday) and 8am to 1pm on Thursdays. Appointments were available to patients during the times advertised. The practice is closed at weekends. The practice offered a number of early morning appointments and a late evening surgery one day a week for patients who may find it difficult to attend in the daytime for example, fulltime workers. Following the inspection the practice told us that their website had been updated to inform patients that the practice was now open from 8am to 8pm on Tuesday's. Patients could make appointments by telephone or in person. 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. Information on the out-of-hours service was provided to patients in the surgery itself, in the practice information leaflet and on their website.

Patients expressed concerns about the problems they have had making appointments by telephone. Patients told us that it could take up to 45 minutes to get through to the practice and sometimes they would not get through at all.

Some patients told us that it was much easier to come into the surgery to make an appointment. They confirmed that they could see a GP on the same day if they needed to or they could wait to see the GP of their choice, which could mean waiting up to two weeks. A survey carried out by the practice confirmed patient concerns. For example patients expressed concerns about the number of appointments available and poor telephone answering. These concerns were also reflected in the 2014 GP national patient survey where 54% of respondents found it easy to get through to the surgery by phone as compared with the local council commissioning group (CCG) average of 72%. At the inspection we heard a patient telling the receptionist that they had to come into the practice to make an appointment because they had tried all morning to get through on the phone and could not get through. The practice was seen to be taking steps to address these issues. We saw an action plan that prioritised improved telephone access and improved access to the patients GP of choice as areas to be addressed. The practice had a website where patients had online access to the practice. Online access allowed patients to for example book and cancel appointments.

The practice had an appointments self-check in system in place. We observed patients using this with ease.

Longer appointments were available for patients who needed them and those with long-term conditions. Named GPs were allocated to care for patients in care homes. Home visits were made to local care homes.

Listening and learning from concerns and complaints

We saw that information was available in the waiting room and in the patient information leaflet to help patients understand the complaints system. Patients told us that they found staff polite and approachable and had not had cause to make a complaint with the way they were treated. Patients felt that if they had to make a complaint they would be listened to and their complaint dealt with promptly.

Minutes we read showed that an annual meeting took place to discuss patient's suggestions and complaints. The minutes were dated October 2014, these showed that 14 complaints had been received for the year and they had been resolved. The meeting was attended by the GPs and the practice manager. We found that the practice could not provide evidence that an initial holding letter went out to

Good

Are services responsive to people's needs?

(for example, to feedback?)

complainants to acknowledge the complaint as outlined in their policy. Information we read showed that patients were contacted by phone and acknowledgement of the outcome of complaints provided in writing or verbally to the complainant. We found that there was an absence of evidence to confirm that complaints were discussed regularly at staff meetings. Information was not available to show that the practice reviewed complaints on an ongoing basis to detect themes or trends. For example, we saw a complaint about a misunderstanding between a GP and relatives following the death of a patient. This had been responded to.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to improve the health of its patients, deliver high quality care and promote good outcomes for patients. This was clearly stated within information produced by the practice. We saw that the vision statement was publicised within the practice. The practice shared with us their vision to deliver high quality care and promote good outcomes for patients. These values were shared with staff at staff meetings and at the PPG meetings. The practice vision and values included the following aims: 'To provide monitored, audited and continually improving health care services' and 'To become a patient centred organisation. All staff told us that they felt strongly about working together as a team to provide positive outcomes for patients.

We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff we spoke with demonstrated their commitment to the vision of the practice to provide high quality care for patients. Staff told us that were asked for their views when the vision and strategy was considered. Staff felt that their comments had been included in the final document.

The partners also had 'away days' where they discussed the plans for the practice. Minutes for these were not distributed to other staff working at the practice. We were told that relevant information was shared with the practice manager and lead nurse who disseminated this to their teams.

Governance arrangements

The management team at the practice comprised one of the GP partners, the practice manager and one of the lead nurse's. Staff at the practice took specific leadership roles. For example one of the partners took responsibility for managing patient information and was the 'Caldicott Guardian'. Information governance is the term used to describe how organisations manage the way information is handled within the health and social care system. It covers the requirements and standards that practices need to achieve to fulfil their obligations that information is handled legally, securely, efficiently, effectively and in a manner which maintains public trust. A 'Caldicott Guardian' oversees the flow of information amongst clinicians involved in direct patient care.

A confidentiality policy had been developed linked to the 'Caldicott' policy. The policy had been approved by the practice in June 2013. Confidentiality clauses were included in employee's contract and handbook. These included details on the Computer Misuse Act 1990. This law covered three areas, access to a computer without permission, access to a computer with the intent of breaking the law and the unauthorised modification of computer files. Staff were asked to sign to confirm they had read and understood these policies.

We found that one of the GPs consulting rooms was not presented as a confidential area to consult and treat patients. The walls were crammed from floor to ceiling with varied information both old and current for example, posters and memos and the desk drawers were overflowing with paperwork. It could not be confirmed that confidential information was not inadvertently being stored in this room.

The other partners had lead roles in other areas such as adult and children health lead, Clinical Commissioning Group (CCG) clinical director, GP appraiser and Safeguarding. Two GP's had links with dermatology, mental health and dementia and a further GP was the lead for diabetes. A practice nurse took responsibility for infection control. The staff we spoke with told us they were clear about their own roles and responsibilities. They said they felt valued and well supported and that if they had any concerns they could raise these easily.

We saw that the practice produced policies to set out expectations and procedures for staff to follow. For example we looked at their equality and diversity policy. This provided staff with a clear statement on discrimination and procedures to be followed related to for example, human rights, culture and religion, bullying and recruitment. Policies and procedures were available and accessible to all staff on a shared drive on desktop computers which did not impact on the patient information system. We found that an overall index of policies was needed with information to show who should review them and when. We saw that some policies had been approved by one of the senior partners but this was not consistent. We saw that paper copies of the policies

Are services well-led?

Good

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

and procedures were located in a folder in the staff sitting room. A system was needed to confirm that staff had been made aware of new and updated policies with evidence to confirm that they had read and understood them.

We saw that the GPs held a practice meeting daily following morning clinics. We sat in on the meeting on the day of inspection. The meeting was informative and provided the GPs with the opportunity to discuss and learn from events that had occurred at the morning clinics. The meeting was relatively informal, not chaired and no notes or minutes taken. Although the meeting lacked focus it allowed for peer support and sharing of patients and updates on anything new. Medical students told us that they found these meetings excellent. It was considered that some of the audits carried out at the practice could be more reflective with reference to the discussions held at practice clinical meetings.

Fortnightly meetings were held with the GPs and practice managers. Actions were not highlighted however it was explained that any action needed would be carried out by the practice manager unless stated otherwise. Practice meetings attended by the GPs, the practice manager and the lead nurse were held approximately monthly. The minutes for this meeting were viewed, these were not detailed with no evidence of action agreed by whom and when. Further smaller team meetings were held; the practice manager met with the reception staff monthly, however admin staff were not included in planned formal meetings. The nursing staff held monthly meetings and had regular meetings with one of the GP partners. There was not an opportunity for a practice meeting where all the various staff groups could meet face to face.

Significant event meetings were held approximately three monthly. These were led by the deputy practice manager. As with other meetings the minutes were not detailed and a record of actions, by whom and timescales were not recorded. An annual meeting was also held to discuss that had occurred during the year. One of the GP partners told us that the significant events with the practice nurses at the monthly clinical meeting.

The GPs had completed a range of audits, both clinical and managerial and used these to monitor the quality of their practice and to identify where action should be taken. For example, We looked at audits in respect of the management of cholesterol reducing prescribing and post-operative wound infection rates following minor surgery or therapeutic injections.

We saw that the practice manager had arrangements in place for identifying, recording and managing risks. We saw that risks included those relating to the building and utilities; those which were linked to staffing, such as sickness or holidays and those which related to patients' health. We saw that there were contingency plans to manage risks. We saw that risk assessments had been carried out in relation to the premises, for example health and safety, fire risk assessments, security of the building and an assessment of cleaning products used at the practice.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 98.6% out of a possible 100 percent. This was above the average score achieved nationally and within the local Clinical Commissioning Group.

The practice had acknowledged and reviewed the QOF quality indicators where they had been identified as underperforming. The practice identified eleven priority areas for example, flu immunisation rates of patients aged 65 and older for the practice was 64% compared with the national average of 73%. The practice had developed a quality improvement plan to address these indicators. The plan was discussed with the commissioning area team and shared with other practices as shared learning where appropriate.

Leadership, openness and transparency

We saw from records and speaking with practice staff and external staff attached to the practice that the practice had an open culture and that all staff were encouraged to raise issues. We saw that when a member of staff had needed to raise a concern, they had been supported to do so, in line with staff management policies. We were shown a clear leadership structure which had named members of staff in

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lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with twelve members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns. One of the partners at the practice is the chair of the Clinical Commissioning Group (CCG). We were told that information from the CCG meetings were shared with staff at practice meetings.

Staff told us that team meetings were held regularly, at least monthly. The practice nurses felt that communication had improved between them and the GPs. One of the GPs meets regularly with the practice nurses and health care assistants. Staff felt that the practice had developed more of an open and inclusive culture. They felt encouraged and supported to raise issues at team meetings. We saw that there was openness, honesty and transparency at a senior level in the practice. This was visible throughout the organisation and staff told us that they felt supported, valued and motivated.

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

We spoke with members of the Patient Participation Group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The PPG representatives told us they were a small group. The practice is actively advertising through posters on the notice board in reception and in leaflets for patients to join the group. This would ensure that the group was more representative of the practice population. Feedback from patients following the annual survey were shared with the members. Members were also encouraged to have a say in plans to ensure patients had a positive experience when they visited the practice. The group had been asked to share their thoughts on improvements to the practice website for example, how the practice could raise its profile and the out of hours service.

In addition to the annual surveys, the practice had trialled a 'friends and family' test and had invited patients to fill in comment cards with their views about whether they would recommend the practice to people they knew. Overall the concerns were generally positive, however some patients echoed the same concerns identified in other patient surveys. These included attitude of reception staff, opening hours, waiting times for appointments, and not being able to get through to the practice on the telephone.

The practice had gathered feedback from staff through annual appraisals, regular formal meetings and informal daily contact. 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 electronically on any computer or as a paper document within the practice. Medical students provided positive feedback on their experience of the practice. They felt that the practice was always willing to help then and enhanced their learning.

Management lead through learning and improvement

The practice told us that they informally discussed significant events and other incidents. We could not confirm that these were shared with staff at meetings to ensure the practice improved outcomes for patients.

The practice had gathered feedback from patients through patient surveys received. We looked at the results of the latest annual patient survey which had been carried out in August 2014 and 98.3% of patients said they found the practice staff helpful or very helpful. The practice showed improved results when compared to the previous year's survey. Ongoing concerns related to access to the practice had been identified and we saw an action plan had been developed to address these concerns.

The practice was a GP training practice and also accredited to provide training for medical students. We found that there was a supportive GP buddying system in place for GP trainees at the practice. This system provided the GP registrars with direct access to GP support each day. The GP registrars also had their own syndicate and attended a monthly forum for networking and to share experiences. We saw that there was also a buddying system for nurses and this role was fulfilled by one of the GPs. One of the trainee doctors told us that they were happy with the support they received at the practice. The induction period for medical students is up to two weeks dependent on the individual needs of the student. Following the induction period a meeting is held between the student and their GP supervisor to agree the student's personal development plan. The Foundation Programme is a two-year training programme for doctors after leaving medical school. It is

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designed to give trainees a range of general experience and enable them to take on supervised responsibility for patient care as a professional in the workplace, before choosing an area of medicine in which to specialise.

We saw evidence where the practice worked together with other key partners who had a common focus on improving quality of care and people's experiences, for example health visitors, district nurses and midwives. The practice worked with others and shared experiences for improvement.

We reviewed a number of human resource policies, for example, equality and diversity, induction and recruitment policies and handling complaints which were in place to support staff. We saw that policies related to staff working practices were also in place these included a lone worker policy for example. Some staff we spoke with knew where to find these policies if required.