Drs Collier, Robinson, Gunstone, O'Reilly & Rakkiannan

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Collier, Robinson, Gunstone, O'Reilly & Rakkiannan on 21 October 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good in 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 were aware of their responsibilities to raise concerns and report incidents.
- Patient care and treatment was considered in line with best practice national guidelines.
- The practice was clean and hygienic and had arrangements in place for reducing the risks from healthcare associated infections.
- Patients said that they were treated with compassion, dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had a trained team of staff who had expertise and experience in a wide range of health conditions.
- The practice encouraged their patients and staff to share their views.

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

The provider should:

- Ensure that systems are in place to show that all staff are informed about new guidance. Have a structured approach to meetings to show that sharing and recording of lessons learned from significant events/ incidents, and near misses are disseminated to staff. Meetings should be minuted to clearly show what was discussed, action to be taken, by whom and when.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. There were enough staff to keep people safe. However, when things went wrong, records were not detailed enough to clearly demonstrate discussions and outcomes. There was also insufficient information to show that lessons learned were communicated widely enough to support improvement.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Clinical Excellence NICE and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify 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. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported that although they had difficulty getting through on the telephone when they got an appointment they were offered a same day appointment and could book appointments in advance. The practice had good facilities and had suitable equipment to treat and meet patient's needs. Patients could access a range of clinics to obtain appropriate care, treatment and support which met their individual needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. 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. Every staff member had received an induction, regular performance reviews and attended staff meetings.

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 district nurses supported the practice to provide vaccines for these patients in their own homes if their health prevented them from attending the clinics at the surgery. Older people were also offered the shingles vaccine in keeping with current guidance. The practice worked with two local care homes to provide a responsive service to the patients who lived there.

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 community matron and district nurses who provided support to patients with long term medical conditions. The practice used the 'Flo telehealth' system to support patients with long term health conditions to be involved in managing their care and treatment. Patients with diabetes were seen more regularly at the practice so that they could be supported to understand and manage their condition.

Families, children and young people

Good

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

Summary of findings

examples of joint working with midwives and health visitors. Systems were in place to manage referrals for children and pregnant women whose health deteriorated suddenly. Midwife led antenatal clinics were held at the practice.

Information was available to young people regarding sexual health. For example, there were free chlamydia testing kits available to 15 – 24 year olds. Family planning advice was offered and young patients were provided with condoms if appropriate.

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. Working age people had access to a pre-bookable Saturday morning clinic. 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. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice. Family planning services and cytology screening were provided to women of working age. The practice offered patients aged 40 to 74 years old a health check.

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. There were no barriers to patients accessing services at the practice. The practice held a register of patients including those with a learning disability and care plans had been developed with the patient and their carer to support their individual needs. Patients with a learning disability had annual health checks and longer appointments were offered people when needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations. Patients were encouraged to participate in health promotion activities, such as weight management and smoking cessation. 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.Care plans were in place for all patients with dementia. We were told copies of these plans were also held in patients' homes.

Summary of findings

What people who use the service say

We spoke with 11 patients at 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. They told us that their privacy and dignity were respected and that they were well cared for. Patients told us they felt comfortable speaking with staff and GPs and that they were listened to by all staff. Overall patients said that they found the practice helpful and friendly. There were three comment cards completed before our inspection. The contents of two of the cards were complimentary about the service and staff. The other card expressed concerns about the service, staff and GPs. Information we saw showed that that these concerns were already being addressed as a complaint by the practice.

Patients said that the problem they mainly encountered was getting through to reception via the telephone to make an appointment and waiting times at appointments. 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.

The patient survey information we reviewed showed mixed responses from patients to questions about their experience of the practice. For example, data from the national patient survey showed that patients performed well in the following areas scoring just below the clinical commissioning group (CCG) area average.

- 92% of respondents said that they had confidence and trust in the last GP they saw at the practice.
- 71% of respondents said that the last GP they spoke to was good at involving them in decisions about their care and
- 81% of respondents said that the last GP they saw or spoke to was good at giving them enough time.

Areas for improvement as identified in the national patient survey included:

- Only 39% of respondents found it easy to get through to the surgery by phone as compared with the local CCG average of 74%
- 58% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern compared with the national average of 81% and
- 59% of respondents would recommend the surgery to someone new to the area compared to the local CCG average of 82%.

A survey carried out by the practice showed that the key issues for some patients were related to access to the practice. For example patients expressed concerns about the number of appointments available, poor telephone answering, and the time it takes to book in at the reception desk. The practice was seen to be taking steps to address these issues.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Ensure that systems are in place to show that all staff are informed about new guidance. Have a structured approach to meetings to show that sharing and recording of lessons learned from significant events/ incidents, and near misses are disseminated to staff. Meetings should be minuted to clearly show what was discussed, action to be taken, by whom and when.

Drs Collier, Robinson, Gunstone, O'Reilly & Rakkiannan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager and an expert by experience (a person who has experience of using this particular type of service, or caring for someone who has).

Background to Drs Collier, Robinson, Gunstone, O'Reilly & Rakkiannan

Gordon Street Surgery provides primary medical services to patients living in the Shobnall area of Burton On Trent, Staffordshire. The practice treats patients of all ages and provides a range of medical services. The Shobnall area of Burton On Trent is one of the most deprived areas in the region. Gordon Street Surgery has a large percentage of its practice population, 58% in the working age group. The practice is a single ground floor building and is easily accessible to all patients. Facilities to support accessibility include disabled access and toilets, a portable hearing loop available for patients who are hard of hearing and an electronic patient call system. There were separate staff facilities located at the rear of the building, including a kitchen, staff/meeting room and several offices.

The team of staff at the practice is made up of five GP partners, two salaried GPs, four practice nurses, three healthcare assistants, two part time practice managers, one part time secretary and twelve receptionists (All receptionists work part time). The practice provides care and treatment for approximately 10,500 patients. There are five male doctors, two female doctors and four female nurses at the practice to provide patients with a choice of who to see.

The practice does not provide an out of hours service to their own patients. They have alternative arrangements in place for their patients to be seen when the practice is closed.

The practice has 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 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

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

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

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

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

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

Before 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 Clinical Commissioning Group (CCG) and the local Healthwatch to tell us what they knew about Gordon Street 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 21 October 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 eleven patients and members of the patient participation group (PPG) who used the service. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed surveys and comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice told us that they 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 NHS prescription. We saw that this had been dealt with in a timely way and details of the learning for the practice were recorded.

We found however, that some of the safety records we looked at such as incident reports and notes of meetings lacked detail to clearly demonstrate a safe track record within the practice over the long term. For example there were no structured agendas and minutes of meetings to clearly demonstrate what had been discussed at meetings, the outcome of the meeting, action to be taken, by whom and when and learning shared with staff. We discussed with the practice their lack of formal records related to incidents. We were reassured by the practice that they would address this.

Learning and improvement from safety incidents

The practice showed us a copy of a significant event audit which had been completed and discussed at an annual review meeting. The audit document showed that nine events or incidents had occurred between May and December 2013. However there was insufficient information to demonstrate what the significant event or incident was and the action taken. GPs told us that significant events were informally discussed at weekly practice meetings. However the practice staff could not when requested provide evidence to show that they had learned from the significant events or that the findings were shared with relevant staff.

We saw that a system was in place to disseminate national patient safety alerts to practice staff. Notes in one of the weekly Friday meetings showed that a discussion about putting a system in place to monitor and ensure that safety alerts had been read and appropriate action taken was being considered.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for these agencies were easily accessible. Flow charts showing the procedure for staff to follow were available in each consulting room.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. The GP had been trained and could demonstrate they had the level of training required to enable them to fulfil this role. We found that not all the staff we spoke with were aware of who the safeguarding lead was. The practice assured us that this would be addressed. Those staff who weren't aware of the safeguarding lead told us that they would speak with their manager if they had a safeguarding concern. We were told that safeguarding concerns were discussed at the informal Friday meetings when necessary. Professionals from the wider multidisciplinary team would be invited to attend the meeting if necessary. We spoke with a midwife undertaking an antenatal clinic at the practice. The midwife told us that they attended meetings at the practice to discuss any safeguarding concerns. It was confirmed that appropriate action was always taken by the practice whenever concerns were identified.

The practice had systems that demonstrated risks to vulnerable children, young people and adults were appropriately managed and reviewed. Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system known as Emis. 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. For example an alert appeared for the follow up of children who persistently failed to attend

appointments, such as for childhood immunisations. The Emis system had recently been implemented at the practice. Staff had received training and were becoming familiar with the system.

The practice had a chaperone policy and staff were aware of this policy and where to locate it. The policy was visible to patients on the waiting room noticeboard but was not available in consulting rooms. The senior practice nurse and practice manager confirmed that they would look at posting this information in consulting rooms. This would act as a reminder to patients that a chaperone was available to them at the time of their consultation. Patients we spoke with confirmed that they were offered a chaperone if a sensitive examination was needed. All clinical staff had received training in chaperoning and demonstrated that they were knowledgeable of the principles. Nurses explained their role was to ensure a patient's dignity was maintained throughout sensitive examinations.

Medicines management

The senior practice nurse explained the procedures for the safe receipt and storage of medicines at the practice. 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 to take in the event of a potential failure. We looked at the daily records made of the fridge temperatures. We discussed these with the practice nurse as the records did not clearly show the dates the temperatures were taken and who had made the record. The practice assured us that these records would be reviewed.

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. To promote safe practice children immunisation clinics were carried out by two nurses.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice employed its own caretaker and cleaner who was also responsible for maintenance work of the premises. There were cleaning schedules in place and cleaning records were kept. 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. We saw that all cleaning equipment, maintenance schedules, were ordered and up to date. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had three leads for infection control. The caretaker who was responsible for infection control related to the general cleanliness of the practice and two clinical leads, a nurse and a GP led on clinically related infection control practices. All three staff 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 through online training. Staff hand washing techniques were observed as part of their annual appraisals.

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. Disposable curtains were provided in consulting rooms and treatment rooms. The curtains were changed every six months. There were also policies on how to deal with needle stick injury and bodily fluid spills amongst others. We saw records that confirmed the practice was carrying out regular checks in line with these policies to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date had been completed in May 2014. Medical engineers from the local hospital checked all medical equipment annually. The annual check was due to be carried out in November 2014. 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 and emergency equipment.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Arrangements were in place for all members of staff, including GPs, nursing and administrative staff, to cover each other's annual leave and other absence where possible. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Staffing levels were monitored weekly and adjustments made if needed.

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 processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building (undertaken by the caretaker), the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We were shown evidence of the last fire safety check.

We saw that the caretaker had completed a risk log, related to the environment. These included for example, risks related to cleaning products used at the practice, maintenance and fire safety. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

We saw 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. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment and had made referrals to specialist advisors. We saw that procedures were in place for making referrals to specialist advisors.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support, anaphylaxis (an allergic reaction) and defibrillation. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis.

Good

Are services safe?

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw that the practice had a business continuity and risk analysis plan. The document detailed the responsibilities of the management team and identified the action staff should take in the event of a disruption in the running of the service. Risks identified included power failure, fire, flood and access to the building. The document also contained relevant information on where to locate essential equipment that may be needed in an emergency. The plan contained the emergency contact numbers that would be needed if emergency procedures had to be implemented. This ensured that some or all of the service could be maintained if an emergency or major incident occurred.

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. For example, one of the GPs explained how they followed guidelines related to the treatment of migraine. Minutes of practice meetings were not available to confirm that new guidelines were disseminated to staff. We were told that informal practice meetings took place weekly. We found that there was not a formal agenda for these meetings. The notes taken at the meetings were not sufficiently detailed to create an audit trail of what was discussed, any learning or action to be taken where appropriate.

The GPs told us they led in specialist clinical areas such as heart disease and asthma and the practice nurses supported this work. Practice nurses also led and managed their own clinics. This allowed the practice to focus on specific conditions such as the management of people with weight problems. Clinical staff we spoke with felt comfortable about asking for and providing colleagues with advice and support. For example, the outcome of an audit on the use of antibiotics was reviewed and discussed with staff to ensure best practice guidelines were followed.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. GPs and nurses were aware of their professional responsibilities to maintain their knowledge so as to ensure the best outcomes for people in their care.

The practice had completed assessments and care plans for patients who were assessed as being at high risk. These patients included those with multiple conditions, elderly patients, and those who met the criteria to avoid unplanned admissions to hospital. We saw that patients with a learning disability received an annual health assessment. At the end of the review the patient was provided with a health action plan which was agreed with them. There were systems in place that ensured babies received a new born and eight week development assessment. GPs and practice nurses told us that patients with mental health difficulties received an annual health review. We saw there was a referral/care pathway to enable GPs to plan the care for patients with mental health difficulties in partnership with local mental health care professionals and specialist community groups.

National data showed the practice was in line with referral rates to secondary and other community care services for some conditions. However the data showed that national standards for the referral of patients with suspected cancers were not been met. A case review shared with us showed that a patient was treated medically for approximately six weeks before they were referred to hospital. The patient was seen at the hospital within two weeks of referral and diagnosed with cancer. The GPs we spoke with told us that referrals were closely monitored. However we were unable to confirm from the notes and minutes of meetings that regular reviews of elective and urgent referrals were held or that improvements to practise were shared with all clinical staff.

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 ethnicity 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.

The practice had a system in place for completing clinical audit cycles. The practice showed us three clinical audits that had been undertaken this year. One example involved the practice looking at their prescribing practice for patients who had had a heart attack or stroke. The outcomes 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 was carried out. Following the audit a further review of urgent appointment bookings were undertaken to determine if they were appropriate. GPs maintained records showing how they had evaluated the service and documented the success of any changes. These audits were ongoing

The GPs told us that clinical audits were also linked to medicines management information, safety alerts or as a

Good

Are services effective?

(for example, treatment is effective)

result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Performance data from the local clinical commissioning group (CCG) showed that the practice was underperforming in one of the standards related to the care of patients with diabetes. The practice identified through audit that some of their diabetic patients might benefit from understanding both their condition and treatment to improve compliance. The outcome of the repeat audit was an improvement in compliance and the overall condition of those patients offered more frequent reviews, support and care.

The team made use of clinical supervision, appraisals and staff meetings to assess the performance of clinical staff. GPs held weekly practice meetings which were attended by the practice managers and senior practice nurse. 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. However it was difficult to evidence that audits were discussed or shared at these meetings. We found that there was not a formal agenda at the practice meetings and discussions about audit were not clearly identified in notes or minutes of meetings.

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 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 had a palliative care register. We saw detailed evidence that three monthly multidisciplinary meetings were held to discuss the care and support needs of these patients and their families. Minutes of meetings showed that each palliative care patient was formally reviewed and changes made to their plan of care as appropriate.

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 outcomes that were comparable to other services in the area. For example in relation to child immunisations.

Effective staffing

Effective staffing at the practice commenced with a formal interview followed by a formal planned induction if appointed. A new member of staff told us about their induction. The formal induction programme covered health and safety training and shadowing a senior member of staff for a week. The new member of staff then worked with a mentor for two weeks before undertaking their own clinics. The member of staff told us that they found their induction prepared them well for their role and to work with the wider team.

All clinical staff had annual appraisals which identified their learning needs, 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. For example one of the nurses was attending a cytology screening training course. The nurse told us that following successful completion of the course cytology screening would be one of her defined roles at the practice.

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

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 patients' needs and manage complex cases. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy that outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. For example one of the GPs told us that hospital discharge letters were discussed with the patient either by telephone or face to face and patient records were updated. We saw evidence of how the practice had to obtain discharge summaries from a hospital after the hospital experienced delays sending them to the practice. Patient test results were flagged as a task on the practice IT system. This task could not be removed until it had been acted on. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every three months 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 district nurses, social workers, palliative care nurses and 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 the practice should note that evidence was only available to confirm that multidisciplinary palliative care formal meetings took place and not what was actually discussed.

We saw that the practice worked with the district nursing teams to assist in the provision of long term condition monitoring and management of care for housebound patients. The practice worked with the local primary care mental health team who offered a self-referral system at a local clinic for patients experiencing poor mental health. Staff confirmed that they worked closely with the local primary care mental health team to support patients who were experiencing poor mental health.

We spoke with staff at two care homes whose patients were registered with the practice. They told us that the practice carried out regular weekly visits to the homes. They also confirmed that the GPs would visit outside these arrangements if needed and responded promptly to any concerns they had. They told us that reception staff were very polite and receptive to them when they phoned the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice told us that some referrals had been made using the 'Choose and Book' system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All of the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

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. These care plans were reviewed annually or more frequently if changes in their health and wellbeing made this necessary. The plans 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). For example one of the GPs we spoke with illustrated their understanding of Gillick competency by describing a scenario related to contraceptive advice.

There were systems in place to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. 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.

Health promotion and prevention

The practice was actively involved in an ongoing Clinical Commissioning Group (CCG) local campaign to try and reduce the pressure on Accident and Emergency (A&E) departments. The practice attended schools and local community events to educate people on how to stay healthy. The practice promoted and offered well person checks at these events, for example blood pressure checks, smoking cessation, dietary and exercise advice, flu vaccinations and hand washing techniques. The focus of the campaign was to educate patients who used the practice and people in the wider community on selecting the right health service at the right time. Information was provided on self-care, NHS 111, pharmacy, GP, walk-in and urgent care centres, and A&E. CCG performance indicators had shown that a high percentage of the of patients registered with Gordon Street Surgery attended the A&E regularly, especially patients from Eastern Europe. The practice was aware of the benefits of being involved in this campaign. Information was not yet available to confirm if this had had a positive impact.

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. We noted a culture within the practice for clinical staff including nurses to use their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, by offering smoking cessation advice to patients who smoked and dietary advice to patients who presented as being overweight.

The practice offered a full range of immunisations for children in line with the Healthy Child Programme.

Flu vaccines, travel vaccinations and the shingles vaccination were also offered in line with current national guidance. Their performance for all immunisations was above 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. All of the practice nurses were trained in performing cervical smears. The practice's performance for cervical smear uptake was on target with the requirements of the CCG. Patients who did not attend for cervical smears were offered various reminders, telephone, letter for example and the practice audited non-attenders annually. Chlamydia screening kits were available for young patients to access discreetly. Condoms were visibly available to patients, however not in a discreet manner. The practice was looking at how they could be more discreet when offering these to patients.

Good

Are services effective?

(for example, treatment is effective)

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. 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 and a plan of care was developed.

We saw that leaflets and posters displayed in the waiting area promoted patients wellbeing by promoting self care and signposting patients to support services available to them in the community. Some posters were available in different languages to support non-English speaking patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence from all these sources showed that 70% of respondents felt the GP had treated them with care and concern. Data from the 2014 national patient survey showed the practice performed at or just above the national average for its satisfaction scores on consultations with doctors and nurses. Data showed that 81% of practice respondents said the GP was good at listening to them, 81% said the GP gave them enough time and 92% had confidence and trust in the last GP they saw or spoke to. The responses to the same questions in reference to practice nurses ranged between 58% and 69%. For example 58% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern compared with the national average of 81%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received three completed cards two of which were positive about the service experienced. Patients said they felt the practice offered the right care and treatment to meet their needs, all staff were polite and that the environment was safe. The other comments related to concerns that had been addressed by the practice. We spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff followed the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. However we saw queues at the practice reception which would allow patients' queuing to overhear conversations at the reception. To help address this, the practice had introduced an electronic booking in system. Patients could book themselves in for their appointment and did not have to queue at the reception desk. The practice was also looking at introducing a system to allow only one patient at a time to approach the reception desk. This would prevent patients overhearing potentially private conversations between patients and reception staff and enable confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 GP national patient survey showed 71% of practice respondents said the GP involved them in care decisions and 77% felt the GP was good at explaining treatment and results. Both these results were average compared to national results.

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 are told to call the practice between 11am and 3.30pm to enquire about test results. Patients were reminded that test results could only be released to the person to whom they relate or someone who had been given prior permission in keeping with confidentiality and data protection guidance.

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 sharing of information across appropriate healthcare teams.

Good

Are services caring?

The practice had undertaken care planning as part of a national enhanced service initiative, for high risk patients and to avoid unnecessary hospital admissions. This included older people and people with long term conditions. Progress on this initiative was discussed at team meetings. Patients care plans had been developed with the involvement of the patient's family or carer as appropriate.

Patient/carer support to cope emotionally with care and treatment

Information we reviewed showed patients were positive about the emotional support provided by the practice. For example, the patients we spoke to on the day of our inspection and the comment cards we received said they had received help to access support services to help them manage their treatment and care when it had been needed. Patients told us that staff responded compassionately when they needed help and provided support when required.

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 patients' waiting room signposted patients to the various support groups. Staff told us that families who had suffered bereavement were called by their usual GP. This call was followed by a patient consultation at a flexible time and location to meet the family's needs.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

GPs and other staff told us that the needs of the practice population were regularly reviewed to ensure appropriate systems were in place to address identified needs. Patients we spoke with told us that they received care that met their health needs. Patients felt that their health concerns were discussed with them and they felt listened to and supported by staff.

The practice reviewed its services to ensure they could maintain the level of service needed. For example due to a recent retirement the practice had a GP vacancy and was looking at how best to fill this vacancy. They had also carried out a review of the number of appointments both face to face, telephone consultations and home visits available for patients. NHS England had also offered their services to support the practice in a full review of their appointments system.

The NHS England 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 waiting area, which included a lowered reception counter access for people who used wheelchairs. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care.

Tackling inequity and promoting equality

The practice had recognised the needs of their different population groups in the planning of its services. For example staff told us that 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. Patients whose circumstances made them vulnerable for example homeless people and people experiencing problems with alcohol or drugs were able to register with the practice.

Staff told us that the practice population was mixed with increasing numbers of Asian and eastern European patients. Staff told us that an external translation service was available for patients who did not have English as a first language. Interpreters were used to support staff to explain health concerns and ensure that patients understand the treatment proposed by the GP. We saw notices in the waiting area informing patents this service was available. Two of the receptionists at the practice were also employed as interpreters and were available to support patients whose first language was Urdu, Hindi and Punjabi if the patient agreed. Information on the practice website could be translated into other languages to meet the needs of patients.

The practice premises were on the ground floor of the building. The premises had been adapted to meet the needs of people with disabilities. We saw that there was easy access to the practice. There were easily accessible disabled toilets for patients and staff and a baby changing facility. To support access for all patients there were a number of facilities to support them such as clear signage and an induction loops for patients who had a hearing impairment. This reduced any barriers to care and supported the equality and diverse needs of the patients.

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

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. The practice manager told us she would investigate these and any learning identified would be shared with staff. We saw an example of a recent incident that showed concerns related to possible discriminatory behaviour was addressed through the PPG and staff group meetings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

Appointment times offered at the practice varied. These were from 9am to 11.35 or 11.40am on weekdays mornings and 3pm to 5.30pm or 5.40pm weekday afternoons with one session from 2pm to 4pm. There was a total of 40 GP clinic sessions per week. Appointments and telephone consultations outside of these hours could be arranged for patients who worked. We saw that additional appointments for urgent health concerns could be added to the end of standard surgery sessions. To ensure all eligible patients could receive flu vaccines, separate flu clinics were held at the weekend. On their website the practice advertised their opening times as 8.30am to 6pm Monday to Friday. They also operated an extra clinic on Saturday morning for working age patients. This clinic offered pre-bookable appointments only.

The practice had an appointments self-check in system in place. We noted at our inspection that patients were queuing to check in with the receptionist and the self-check in system was not being used. Patients we spoke with told us that they had not been shown how to use the system. We mentioned this to the practice manager and saw a receptionist instructing patients on how to use the system.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the surgery itself and in the practice information leaflet.

The practice had a website where patients had online access to the practice. Online access allowed patients to for example book and cancel appointments.

Patients expressed concerns about the problems they have making appointments by telephone. Patients told us that it could take up to an hour 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 showed that the key issues for some patients were related to access to the practice. For example patients expressed concerns about the number of appointments available, poor telephone answering, and the time it takes to book in at the reception desk. These concerns were also reflected in the national patient survey where only 39% of respondents found it easy to get through to the surgery by phone as compared with the local council commissioning group (CCG) average of 74%, The practice was seen to be taking steps to address these issues. To support them in the review of the appointment system the practice had accepted the offer of support from NHS GP Support Service. The practice was awaiting the outcome of this review.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handles all complaints in the practice.

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.

We looked at a summary of the complaints received by the practice. This showed that nine complaints had been received for the year 2013/14 and six complaints had been received to date for 2014/15. We found these had been handled and resolved promptly in line with the practice's complaints policy. The practice reviewed complaints on an ongoing basis to detect themes or trends. We checked the reviews and saw that lessons learnt from individual complaints had been acted upon. 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 in a timely manner and in person to effectively resolve the complainants concerns.

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 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 Patient Participation Group (PPG) meetings. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice vision and values included the following aims: 'To show our patients courtesy and respect at all times irrespective of ethnic origin, religious belief, personal attributes or the nature of the health problem'. The practice did not have a formal business plan. The practice manager told us that changes to be made were discussed amongst the partners and then with the team of staff where appropriate. For example discussions were held to decide on the refurbishment that would take place in the practice waiting area. We spoke with 14 members of staff they all knew and understood the vision and values and knew what their responsibilities were in relation to these. All staff told us that they felt strongly about working together as a team to provide positive outcomes for patients.

The practice was undergoing changes due to the recent retirement of one of the GPs. Arrangements to ensure a smooth process of succession of senior partner had been considered. However a strategy for the proposed replacement for the GP vacancy to maintain meeting the needs of their patients had not been considered. At the inspection one of the partners told us that one of their plans going forward was to recruit an advanced nurse practitioner. Advanced nurse practitioners are highly skilled nurses who would have the skills to diagnose and treat patients healthcare needs independently, and to refer them to an appropriate specialist if needed.

Governance arrangements

The management team at the practice was made up of one of the GP partners, two practice managers and the senior practice nurse. There was a clear leadership structure with named members of staff in lead roles. For example, one of the practice managers led on Caldicott. The aim of Caldicott was to ensure that every use or flow of patient-identifiable information would be regularly justified and routinely tested against the principles developed in the Caldicott Report. The designated lead person ensured that the practice fulfilled their obligations to handle patient information legally, securely, efficiently, effectively and in a manner which maintains public trust. The other practice manager was responsible for staff recruitment and staff records, and the senior GP partner was the lead for safeguarding in respect of children and vulnerable adults. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to at the practice with any concerns.

The practice had produced policies and procedures both for clinical practise and policies related to staff so that they were clear of what was expected of them. Policies available and seen by us included whistleblowing and dealing with complaints. We saw that policies and procedures were reviewed at least annually, more often if required. Staff had access to these on computers or in files in their office areas.

The practice held informal weekly meetings for all GPs, practice managers and the senior practice nurse. Records we looked at showed that there was not a formal agenda for this meeting and only brief notes were made. GPs told us that at these meetings significant events and complaints were discussed informally. The practice was unable to evidence that formal governance meetings took place. The practice manager held regular meetings with reception and administration staff. The lead nurse held monthly meetings with the nurses and healthcare assistants.

The GPs had completed a number of both clinical and managerial audits and used these to monitor the quality of their practice and to identify where improvements were needed. Examples of audits we saw included patient management of their diabetes, medication management and appointments.

The practice was able to evidence that they had robust arrangements for identifying, recording and managing risks. We saw that risks identified were related to the building, utilities, managing sickness and dealing with emergencies. We found that the management of risks was not a formal agenda item at any of the meetings held at the practice. We found that the caretaker had undertaken risk assessments in relation to the premises, for example fire risk assessments, security of the building and an assessment of cleaning products used at the practice.

Are services well-led?

Good

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

We saw that the GP partners monitored and reviewed the financial health of the practice to ensure they could meet patients' needs and maintain the fabric of the building.

We saw that the practice used the Quality and Outcomes Framework (QOF), a national performance measurement tool, to measure its performance. The QOF data for this practice showed it was performing at or just below national standards. There was evidence that a number of the audits undertaken were in response to national standards where the QOF score for the practice was lower than the national average. For example the practice had looked at the care of patients with diabetes and antibiotic prescribing. We could not see evidence that QOF data was regularly discussed at monthly team meetings and this information shared to maintain or improve outcomes. Both NHS England and the clinical commissioning group (CCG) have told us that contract information from the practice is often late and they regularly have to make repeated requests for the information.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. 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. Staff we spoke with demonstrated their commitment to the vision of the practice to provide high quality care for patients.

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 mental health specialist advisors.

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

The practice had gathered feedback from patients through patient surveys, suggestion boxes and complaints. Some of the comments received from patients had a common theme of the waiting room not being very inviting or comfortable. The practice manager showed us improvements which had been made to the waiting area which included a new reception desk with access for patients in wheelchairs, new chairs and redecoration. The practice also provided an update for patients on the action they had taken in response to their concerns and comments. This was done through notices in the waiting room.

The practice had an active patient participation group (PPG). The group met every three months and was sometimes attended by GPs at the practice. The meetings had a formal agenda and minutes were taken. We were shown detailed minutes of the meetings held between November 2013 and October 2014. The PPG had been involved in the surveys carried out at the practice. Topics discussed at the meetings included appointments, staff, and the refurbishment of the waiting/reception area. The PPG were involved in the changes to the waiting area.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. We saw that new staff including locum GPs had a formal induction programme, this involved the new member of staff shadowing staff throughout the practice and being assigned a mentor.

We saw that nurses and GPs kept their continuing personal development up to date and attended courses relevant to their roles and responsibilities for example infection control, cytology and diabetes. This ensured that patients received care and treatment based on current guidance.

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. We did find that complaints were formally discussed and

Are services well-led?

Good

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

reviewed. A summary we read showed details of the complaint, action taken to investigate, details of the response to the complainant and the learning shared with all staff.