Moorfield House Surgery

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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Moorfield House Surgery on the 28th October 2014 as part of our new comprehensive inspection programme. Our inspection team was led by a CQC Inspector and included a GP specialist advisor and a practice manager specialist advisor.

We have rated the practice as good.

Our key findings were as follows:

- Patients were highly complementary about the staff and the care and treatment they received.
- Staff understood the importance of raising concerns and reporting incidents.
- There was a systematic approach to clinical audits and learning from the findings.
- Patients were treated with courtesy and respect and felt involved in their diagnosis and treatment.
- Patients were able to get an appointment convenient for them.
- The practice sought and acted upon feedback from staff and patients.
- There was an open and supportive culture which encouraged high standards.

We saw areas of outstanding practice including:

- The care of patients with long term conditions.
- The joint working with care homes and social services in the care of vulnerable elderly patients.

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

In addition the provider should:

- Minutes of practice meetings did not include details of any significant events which had been discussed. Whilst significant events were investigated and reported to the local Clinical Commissioning Group there was no up to date practice record to aid staff in identifying patterns or themes.
- Medicine storage cupboards were not secured by key locks and there was no system to restrict access only to authorised staff.

Summary of findings

- There was no system to record the serial numbers of prescription pads issued to the doctors.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff were aware of and understood their responsibilities to raise concerns, and report incidents. Lessons were learned and shared with staff to support improvement. Risks to patients were appropriately assessed and well managed. Safety information was monitored and action taken where required.

Are services effective?

Good

The practice is rated as good for effective. Systems were in place to ensure that clinicians were up-to-date with published good practice guidance and used them to improve clinical practice and outcomes for their patients. We saw data that showed that the practice was performing highly when compared to neighbouring practices in the CCG.

Are services caring?

Good

The practice is rated as good for caring. Patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy and staff were clear about their responsibilities. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice had an active Patient Participation Group (PPG) and sought the views of staff and patients.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice offered proactive, personalised care to meet the needs of older people. Nationally reported Quality Outcomes Framework (QOF) data showed the practice had good outcomes for conditions commonly found amongst older people. The practice was responsive to the needs of older people, offering home visits and annual health checks for housebound patients, weekly 'ward rounds' and annual health checks for patients living in residential care homes and follow up health checks for those who had been discharged from hospital.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the population group of people with long term conditions. The practice had a well-qualified nursing team which provided twice yearly reviews for patients with long term conditions. The practice had adopted the 'Year of Care' approach for patients with diabetes. Patients were provided with additional information about their condition. They were encouraged to be more proactive in managing their condition and were aware of when to seek help.

Families, children and young people

Good ●

The practice is rated as good for the population group of families, children and young people. There was good joint working with midwives and health visitors. National QOF data showed the practice had attained maximum points for cervical screening, child health surveillance, contraception and maternity services. New patient health checks were available. Urgent and/or telephone appointments were available for parents and young children. Systems were in place for identifying and following up of children who were at risk.

Working age people (including those recently retired and students)

Good ●

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice provided

Summary of findings

extended access on Mondays and Thursdays. The practice was also proactive in offering telephone and online services as well as a range of health promotion and screening which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding 

The practice is rated as outstanding for the population group of people whose circumstances may result in them being vulnerable. Links had been made with local health and social care teams and joint monthly patient review meetings took place to discuss the most vulnerable patients. The practice held a register of patients with learning disabilities and offered them annual health checks and longer appointment times. Information in large print and easy read formats was available. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good 

The practice is rated as good for the population group of people experiencing poor mental health, including people with dementia. There were regular physical reviews for patients with mental health problems, drug monitoring of those at high risk, signposting to psychology and counselling services and checks for early signs of dementia.

Summary of findings

What people who use the service say

During our visit we spoke with five patients, two members of the PPG and received 22 completed CQC comment cards. Patients spoke very highly of the practice and the standard of the care and treatment they received. They said the staff were caring and professional and they were always able to get an appointment when they needed one.

Of the 116 patients who responded to the most recent National GP Patient Survey, 99% said they had confidence and trust in the last GP they saw or spoke to. There were also high levels of satisfaction with the practice appointments system. Of those who responded 98% said they found it easy to contact the surgery by telephone and 96% described their experience of making an appointment as good. The practice's own survey of 303 patients identified similar levels of satisfaction.

Areas for improvement

Action the service SHOULD take to improve

- Minutes of practice meetings did not include details of any significant events which had been discussed. Whilst significant events were investigated and reported to the local Clinical Commissioning Group there was no up to date practice record to aid staff in identifying patterns or themes.
- Medicine storage cupboards were not secured by key locks and there was no system to restrict access only to authorised staff.
- There was no system to record the serial numbers of prescription pads issued to the doctors.

Outstanding practice

- There was a focus on improving outcomes for patients and developing the roles of the practice nurses and healthcare assistants to support patients with long term conditions. The practice had adopted the 'Year of Care' approach for patients with diabetes. Patients were provided with additional information and encouraged to be more proactive in managing their condition.
- The practice had established links with staff from the local integrated health and social care teams and they were invited to attend monthly review meetings to discuss the most vulnerable patients. The practice had established close links with the local care homes. Named GPs were available as key points of contact and weekly visits were undertaken to review patients registered with the practice.

Moorfield House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a General Practitioner and a Specialist Advisor with experience of working as a practice manager.

Background to Moorfield House Surgery

Moorfield House Surgery is located in the Garforth, a semi-rural area of Leeds. The practice provides primary care services, under the terms of a Personal Medical Services contract, for approximately 4300 patients. The practice list is open to new patients living in the practice area. The number of registered patients has increased by 160 in the last six months. There are three doctors at the practice, two male and one female. They are supported by two practice nurses, a healthcare assistant and an experienced administrative team. Staff turnover is low and the staff know many of the patients.

The practice is open each weekday between 8 am and 6 pm. An extended service is available from 7.30 am on Mondays and Thursdays. The availability of appointments is good. Regular clinics are available providing advice and treatment for; smoking cessation, chronic disease management and health promotion. Weekly ante-natal care clinics are provided at the surgery by the community midwife. The practice does not open at weekends. Out of hours care is provided by Local Care Direct.

Patients aged over 65 years account for approximately 21% of the registered practice population. This figure is higher than the England average (16%). Approximately 18% of patients registered with the practice are aged under 18 years, which is lower than the England average (21%).

The practice scores highly in patient surveys. The findings of the most recent national GP survey showed that; 99% of respondents had confidence and trust in the last GP they saw or spoke to, 96% had confidence in the nurses, 98% found it easy to contact the practice by telephone and 96% described their experience of making an appointment as good.

The practice is registered with the CQC to provide the following regulated activities:-

- Treatment of disease disorder or injury
- Diagnostic and screening procedures
- Surgical procedures
- Family planning

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before the inspection visit we reviewed information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 October 2014. During our visit we spoke with two of

Detailed findings

the doctors, the lead nurse, the practice manager, reception and administrative staff as well as five patients who used the service. We also spoke with two members of the Patient Participation Group and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care 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 had systems in place to regularly monitor and assess the safety of care and treatment provided. These included monitoring of safety alerts, patients' outcomes, participation in peer reviews, clinical audits and an annual assessment by the local Clinical Commissioning Group (CCG). The performance of individual staff was monitored through clinical supervision and annual appraisals. The staff understood their responsibilities to raise concerns, to record safety incidents and near misses, and to report them where appropriate.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant incidents. The clinical team and practice manager met monthly to review performance. The meetings included discussion of significant safety incidents, selected complex cases, all new cancer diagnoses and recent deaths. Staff told us learning from events or incidents was also discussed at twice yearly whole team meetings. However, incidents requiring immediate changes to systems or procedures were dealt with immediately.

Details of all significant incidents were recorded using bespoke patient safety and adverse event reporting software widely used in the NHS (DATIX). The information was shared externally with the CCG to promote wider clinical learning. We checked all the significant incidents that had been reported since 2010. The information recorded was comprehensive and included details of the investigation and learning outcomes. The GPs had also recorded details of significant incidents in their appraisal folders. However, there were no specific records of significant incidents in the practice meeting records and the practice had not maintained its own summary record to enable them to identify patterns or themes.

Where incidents had involved an individual patient they were given an apology and informed of any actions taken as a result. For example, we were told of an incident involving an error with a repeat prescription. An immediate investigation had been carried out and the patient contacted personally with an apology. However, formal recording of such incidents was not always completed in a way which allowed the practice to easily monitor any patterns or trends.

Reliable safety systems and processes including safeguarding

The practice had established systems to manage and review risks to vulnerable children, young people and adults. On-going safeguarding concerns, including reviews of looked after children, were discussed at practice clinical team meetings. Staff had undertaken safeguarding training appropriate to their role. One of the GPs had been appointed as the lead for safeguarding and had completed Level 2 training. At the time of our visit we were told arrangements had been made for the GPs to complete Level 3 training in accordance with current recommended guidance for general practitioners.

Staff were able to give examples of possible signs of abuse of vulnerable adults and children. They were aware of their responsibilities to report and document safeguarding concerns and how to contact the relevant agencies. Contact details of local health and social care safeguarding services were displayed in the consulting and treatment rooms. Information about support for people experiencing domestic violence was available in the patient waiting areas.

Medicines management

Overall arrangements for management of medicines, including; prescribing, recording, storage and disposal of medicines ensured the safety of patients. However, there were some shortfalls in the arrangements for the security of medicines and prescription pads. For example, whilst medicines were stored in areas only accessible by staff the medicine cupboards were not fitted with key locks. There was also no system to record the numbers of prescription pads issued to the doctors.

Vaccines were stored in temperature controlled refrigerators. Daily checks were made of the internal refrigerator temperature and records were kept to confirm vaccines had been maintained at the temperature recommend by the manufacturer. Stocks of emergency medicines, including those kept in doctor's bags, were available and within their usable date.

Good

Are services safe?

Systems were in place to check and record information received from other services about individual patients, for example; hospital discharge letters and out-patient clinics. Patients prescribed medicines such as warfarin, which required regular monitoring, were reviewed at least twice a year. The practice was notified when patients had failed to attend for their routine blood tests and they were followed up before further medication was prescribed. Blood test results for patients prescribed 'amber drugs' (drugs prescribed under the shared care of a hospital consultant and the patient's GP) were carefully monitored and repeat prescriptions only issued after acceptable test results had been obtained.

Medication audits, including audits of repeat prescribing, were carried out on a regular basis and the findings discussed at practice clinical team meetings. We saw evidence to show that learning from audits had been used to improve the treatment provided and reduce the risks to patients. For example, an audit of the use of oral hypoglycaemic medicines for the management of diabetes had resulted in changes to prescribing which had positive benefits for patients. This reduced the risk of falls and accidents whilst driving as the risk of overtreatment had been addressed.

Cleanliness and infection control

The practice was well maintained and visibly clean. Impermeable flooring had been fitted to the treatment rooms. Patients told us they had no concerns about the standards of cleanliness and infection control at the practice. The practice nurse had been appointed as the lead clinician for infection control. Appropriate infection control policies and procedures were in place and described staff roles and responsibilities.

Single use surgical equipment was bagged and neatly stored ready for use. Supplies of personal protective equipment (gloves and aprons) were available for staff to use. Foot operated waste bins were provided in the consulting and treatment rooms. Clinical and non-clinical waste was separated and stored securely for disposal by an authorised waste contractor. Body fluid spillage kits were available for use by the staff.

Signage was displayed describing correct hand washing techniques and supplies of hand washing materials were available at all hand wash sinks. The sinks fitted in the consulting and treatment rooms were fitted with hand turn taps and plugs. The practice may find it useful to consider the guidance issued by the Department of Health (Health Technical Memorandum 64) and prioritise replacement of these sinks when resources are available.

Cleaning schedules were in use and recommended colour coded cleaning equipment was provided. Disposable paper rolls were fitted to examination couches. Fabric privacy curtains were in use and laundered at twice yearly or when soiled. Cleaning and infection control procedures had been audited twice in the previous 12 months and improvement actions, such as a programme of refurbishment of the consulting rooms, identified.

Equipment

The practice manager was responsible for ensuring the practice premises and facilities complied with health and safety requirements. Environmental risk assessments were carried out. Systems had been put place to ensure equipment used at the practice was correctly maintained and safe to use. Equipment records were kept detailing when each item was checked, and where appropriate calibrated. Records of checks on portable electrical appliances (sometimes referred to as PAT testing) were also available.

Staffing and recruitment

The practice's recruitment and selection policy set out the procedure for the appointment of new staff. We checked the personal files of two recently appointed members of staff and confirmed that the appropriate pre-employment checks had been completed. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

During our visit we noted that there were sufficient staff in reception to attend promptly to patients arriving for their appointment and respond to telephone calls and queries. We were told the practice did not use a locum agency and preferred, when necessary, to use locum doctors who were well known to the practice and patients.

Monitoring safety and responding to risk

Staffing levels and skill mix were planned and monitored so that people received safe care and treatment. Two practice nurses and a healthcare assistant had been recruited in the previous 18 months to strengthen the clinical team. Consideration had also been given to the age profile of the

Good

Are services safe?

staff and succession planning. One of the existing partners was due to retire at the end of 2014 and a new GP Partner had already been recruited to ensure there was no loss in clinical capacity.

The majority of staff at the practice were long serving. They were familiar with each other's roles and were able to cover for absences. They knew many of the patients and were alert to the importance of reporting any changes in behaviour or appearance which may indicate deterioration in a person's health or wellbeing.

Arrangements to deal with emergencies and major incidents

The practice business continuity plan had been updated in September 2014. Arrangements were described for the continuation of the care and treatment for patients in the event of disruption to essential supplies or services, including the temporary or permanent loss of the practice building.

Staff had undertaken CPR training appropriate to their role, for example annually for clinical staff. Resuscitation equipment, including a defibrillator, was available and staff had been trained in its use. Fire safety equipment was available and there were records to show it had been regularly tested, sound tests of the fire alarms were carried out weekly. Staff were aware of fire alarm and evacuation procedures. However, these were not routinely tested and the practice may find it useful to review these arrangements and assess the effectiveness of their plans.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patient's needs were assessed and their care delivered in line with evidence-based guidance, standards and best practice. Members of the clinical team were responsible for specific treatment areas, for example diabetes, asthma or chronic obstructive pulmonary disease (COPD). Time was allocated at practice clinical team meetings for consideration of updates or changes to best practice guidance and legislation. The information was used to develop services and how care and treatment was delivered. Patients aged over 75 years all had named GPs. Care homes within the practice area also had a named GP contact. Extended access, from 7.30 am on Mondays and Thursdays and from 8.00 am the other days, was available to assist working age adults. Appointments, which were also bookable online, were available with a GP or nurse, in person or by telephone.

Management, monitoring and improving outcomes for people

The practice participated in local audits and peer reviews. The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included; urgent cancer referrals, prescribing and soft tissue injections. Clinical templates had been developed for patients with long term conditions. This promoted the adoption of evidence based care and the consistent recording of information.

The practice had recruited and trained a well-qualified nursing team. There was a focus on further improving outcomes for patients and developing the roles of the practice nurses and healthcare assistants to support patients with long term conditions. The practice had adopted the 'Year of Care' approach for patients with diabetes. Patients were provided with additional information about their condition and encouraged to be more proactive in managing their condition. For example, patients were referred to the Expert Patients Programme to help them improve their health and wellbeing and manage their condition on a daily basis. Patients were also routinely referred to retinal screening and podiatry (foot care) services.

Effective staffing

The practice Study and Training Policy included provisions for annual training need assessments, requests for study time and eligibility for assistance. The members of staff we spoke with felt they were well supported and had been able to access training to improve their skills and knowledge. They had annual appraisals, which included a review of their training needs and personal development plans. They said they were encouraged to undertake further training and development related to their role.

Clinical staff had personal development plans and participated in regular Continuing Professional Development (CPD) sessions and annual appraisal. The doctors were also engaged in revalidation by the General Medical Council. Discussions of significant events, audits, palliative care and safeguarding meetings were also used as opportunities to develop effective care and treatment.

Working with colleagues and other services

There were clear arrangements for the checking and filing of test results, patient letters, out of hours attendances and hospital discharge letters. Referrals to other services were managed by the GPs. The practice had established links with staff from the local integrated health and social care teams and they were invited to attend monthly review meetings to discuss the most vulnerable patients. The practice worked closely with the local care homes. Named GPs were available as key points of contact and weekly visits were undertaken to review patients registered with the practice.

Information sharing

Staff from the local palliative care team attended practice clinical team meetings to share information about patients receiving end of life care. Information needed to plan and deliver care and treatment was shared appropriately and available to relevant staff. When patients moved between services, including at referral and discharge, the information needed for their ongoing care was shared appropriately. Systems used to manage information about each patient's care and treatment were used to assist staff to deliver effective care and treatment.

Consent to care and treatment

Clinical staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The clinical staff were aware of the

Good

Are services effective?

(for example, treatment is effective)

requirements of legislation relating to Deprivation of Liberty and assessed patients on admission to the care homes in the practice area. The clinical staff were aware of current guidance and the requirement to carry out an assessment of capacity to consent when providing care and treatment for children and young people. These are often referred to as 'Gillick competencies' and are intended to help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

Patients were able to access health advice, both at the practice and via the practice website. All new patients were offered an appointment for a health check. The practice participated in the local CCG bowel cancer screening initiative. Housebound patients and those living in residential care homes were offered annual health checks and the convenience of a visiting phlebotomist. Patients aged over 65 years were offered an annual medication review. Annual influenza vaccination of patients aged over 65 was high (80% in 2013). Similarly 65% of carers aged 65 and under had received an annual health check and influenza vaccination.

The practice nurses had undergone health promotion training and offered advice on blood pressure, diet, weight, smoking, alcohol consumption, exercise and healthy living. Screening was available for; chlamydia, cardiovascular disease, diabetes, asthma and chronic obstructive pulmonary disease (COPD). Programmes were in place to deliver childhood immunisations, influenza/pneumonia vaccinations for patients over 65 and those at risk.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice scored highly in patient surveys. The findings of the most recent national GP survey showed that; 99% of respondents had confidence and trust in the last GP they saw or spoke to, 96% had confidence in the nurses, 98% found it easy to contact the practice by telephone and 96% described their experience of making an appointment as good.

Staff understood and respected people's differing personal, cultural and religious needs. Patients were complimentary about the staff and the respectful and considerate manner in which they addressed and interacted with people. The staff were aware of the importance of ensuring the dignity and privacy of patients. For example, issues had been identified in relation to confidentially in the waiting areas and the practice had sought to address concerns by playing background information/televised discussion programmes during surgery times.

Information about the availability of chaperones was displayed in the practice waiting areas. Privacy curtains were fitted to screen the examination couches. Staff who acted as chaperones had received appropriate training. They were aware of their responsibilities to maintain the dignity of patients and the importance recording their presence in the patient's notes.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us the staff took time to explain their care and treatment. One patient told us how they supported a relative at their appointments. They said the GP took time and involved them and their relative in the discussion about their relative's care and treatment. We spoke with a patient attending for their regular six-monthly assessment. They told us they were always informed about their test results and were given information to help them manage their own care. Another patient told us the staff always informed them beforehand if their appointment was with a new member of staff so they knew what to expect.

Patient/carer support to cope emotionally with care and treatment

Patients were given appropriate support and information to cope with their care or treatment. Emotional support and information was provided for relatives or those close to patients, for example when supporting people with mental health concerns or following bereavement. The practice had adopted the 'Year of Care' approach for patients with diabetes. Patients were provided with additional information about their condition and encouraged to be more proactive in managing their condition. There was access to expert patients programme to help them improve their health and wellbeing and manage their condition on a daily basis. Patients with diabetes were also routinely referred for retinal screening and podiatry (foot care) services.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Information about the practice's Quality and Outcomes Framework (QOF) performance was used to inform how services were planned and delivered to meet the needs of patients. Similarly, assessments of the practice's performance by the local Clinical Commissioning Group (CCG) contributed to decision making about service provision.

The services provided reflected the needs of the patient population and offered flexibility, for those with particular needs, for example; long-term conditions, carers, preference for a named doctor or a home visit. Reception staff had flexibility to add additional appointments to each session so as to ensure all urgent requests to see a doctor were met.

The practice had established and supported a Patient Participation Group (PPG). The group, which had approximately 14 regular members, met three/four times a year. The practice manager, practice nurse and one of the GP partners attended the meetings. We spoke with two members of the PPG. They were very positive about the PPG and felt their comments and contributions to the practice were welcomed and valued. They had carried out a survey of patient opinions, produced a report which was available on the practice web site and discussed the findings with the practice. They said the issues they had raised had been considered and where possible changes made. For example, to address confidentiality concerns in the waiting areas.

Tackling inequity and promoting equality

Services were planned to take account of the needs of different people, for example on the grounds of age or disability. Staff were proactive in identifying patients with particular needs and assisting them to obtain a convenient appointment or access a ground floor consulting room. Links had been made with the local integrated health and social care team. Joint meetings were held to review patients most at risk. Patients with a learning disability were offered annual health checks and longer appointment times.

Access to the service

Patients spoke highly about their ability to contact the practice and obtain a convenient appointment. Appointments could be made in person at the practice, by telephone or on-line. The reception staff were able to prioritise any urgent or higher risk patients, for example young children, and ensure they were seen by a doctor. Patients said the staff were very helpful and tried to be flexible to ensure they were given an appointment convenient for them. On the afternoon of our visit we were told the next available urgent appoint was at 5.30pm and the next bookable routine appointment was in two days. However, we were also advised that additional routine appointments would be available to book when the practice opened the following morning.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Information about the complaints policy and procedure was available on the practice web site and displayed in the patient waiting areas. The details included timescales for dealing with the complaints and how to escalate complaints that had not been adequately resolved. Comments and complaints forms were available to use and patients were encouraged to express their views about the practice and the services they received. The patients we spoke with told us they had never had cause to complain or raise a concern about the service. The practice's complaints record detailed one (verbal) complaint in the previous 12 months. The details of the complaint had been recorded together with attempts by the practice to resolve the complaint and the outcome.

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

Staff told us there was good team work and a caring and supportive philosophy at the practice. They said the practice sought to be responsive to the needs of patients and described the ethos as seeking to provide excellent care in a family practice. The practice's Statement of Purpose (a document health and social care providers are required to have available) summarises its aims as being to provide personal health care of a high quality and to seek continuous improvement of the health of the practice population. The practice had also produced a 'Practice Charter' which detailed rights and responsibilities of patients and what they should expect from the practice.

The whole staff team met twice a year to discuss the performance of the practice and plans to improve the service. The doctors and practice manager met each month to review their strategy to achieve these aims. They had reviewed the practice's strengths and weaknesses and were alert to future pressures, including a growth in patient numbers and the opportunities to respond to them. They could articulate their plans but told us they had had not yet formally documented them. However, we were also told that time had been set aside to develop a full business plan early in 2015 following the appointment of a new GP partner.

Governance arrangements

The GPs were assigned lead roles for specific clinical and management areas of the practice. There were robust arrangements for identifying and managing risks and recognition of the need to improve recording. There was a programme of clinical and management audits to monitor the quality of the service and improvement activities. Systems for prescribing warfarin and disease-modifying drugs were safe, and regular reviews were carried out in the areas of referral and prescribing. Staff were clear about their individual roles and responsibilities and felt supported to achieve high standards.

Leadership, openness and transparency

There was effective leadership from the clinical and management team. They had a good understanding of the practice's strengths and the areas for improvement. There were clear priorities for the leadership and development strategy for the leadership team, which included succession planning. The culture centred on the needs and experience of patients. Staff felt they were valued and their commitment to the practice was appreciated. They gave an example of being supported by the doctors when dealing with an abusive patient. There was an open and supportive culture which encouraged staff to raise concerns or comment on the quality of the service.

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

The practice staff understood the value of raising concerns and took account of patient feedback. The PPG had carried out annual surveys of patients' opinions about the service and the treatment they had received. The practice and PPG had most recently surveyed patients during December 2013 and January 2014. In total 289 (91%) of the patients invited to complete the survey responded. The results were considered by the practice and PPG and where appropriate improvement actions identified, for example to promote more use of on-line booking of appointments and improve confidentiality in the upstairs patient waiting area.

Management lead through learning and improvement

Staff told us there was a culture which encouraged learning and development to improve the quality of the service. Staff met twice yearly to discuss the development of the practice. Other training (sometimes referred to as Target days) was also used to brief staff on current issues or development but it was acknowledged these were not always used effectively and in future the focus needed to be more proactive.