Firs House Surgery

Quality Report

Firs House
Station Road
Impington, Cambridge
CB24 9NP
Tel: 01223 234286
Website: www.firshouse.com

Date of inspection visit: 30 June 2015
Date of publication: 13/08/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Firs House on 30 June 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing responsive and for being well led. It was also outstanding for providing services for the elderly, people with long term conditions, families, working age people, people who's conditions may make them vulnerable and people experiencing poor mental health . It was good for providing caring, effective and safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice had developed an intranet that communicated with staff. This shared a large amount of clinical and organisational data and had been adopted by other providers in the Clinical Commissioning Group (CCG).
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice offered a wide range of specialised clinics and the practice had reached out to the local community by approaching community events, churches, schools and had attended them to promote better health. If any underlying health issues were identified the patients were offered an appointment at the practice and patients from other practices were advised to attend their own GP.
- The practice had identified 500 patients where there were clinical indications to offer medication to reduce cholesterol. They carried out a clinical trial offering these patients extended appointments to explain the benefits and risks from that medication. The results of this trial are awaiting publication.
- The practice has an extremely engaged and active patient participation group (PPG) with over 800 members participating remotely, as well as regular face to face engagement. We saw examples of the PPG being able to influence practice behaviour to benefit patients and organise health promotion events.

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. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing well when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

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. Nationally reported data from 2013/2014 showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

We saw evidence of GPs' excellent relationship with management at care homes, attending them regularly through the day including weekends and evenings. The management teams of both the practice and social care settings met regularly to discuss patients' needs.

Each home had a dedicated GP and all residents received a health check when they moved in.

The practice maintained a register of patients discussed at the multi-disciplinary team meetings (MDT) and each of these patients had a care plan that was reviewed every three months.

We also saw that the practice financially supported a community minibus so that elderly patients could attend the practice for appointments and the GPs' regularly attended community events as well as liaising with dementia care contacts.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding 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

Summary of findings

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 examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered appointments early morning, late evenings and some Saturday mornings. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. The practice had 150 registered patients from the traveling community; these patients remained registered at the practice, even if they were travelling away from the practice area.

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

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice reception team had received training in how to support patients with mental health needs.

Summary of findings

The practice had informed patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with ten patients on the day of our visit and two members of the patient participation group (PPG). The PPG is a group of patients who work with the practice to discuss and develop the services provided. Prior to the inspection we provided the practice with CQC comment cards inviting patients to tell us about their experience of the practice. We reviewed 21 comment cards that were completed by patients who had recently used the service. We also looked at the results of the latest national GP patient survey before our visit.

The chairperson from the PPG described a thoroughly integrated working relationship with the practice and the group felt able to influence decisions about how care was provided. The practice had over 800 members in its virtual PPG and regularly engaged with them.

The feedback and comments we received about the practice were extremely positive about the service and staff. Patients told us that they were very satisfied with the services they received. They told us the staff were friendly, helpful, that they felt listened to and involved in decisions about their care. This was also confirmed by the feedback from the national GP patient survey.

We spoke with the managers of two care homes where the practice provided GP services; both of these managers described the GPs as exemplary. They told us that they never had any problems in getting the GPs to visit and this would always be on the same day requested. They told us that GPs made unprompted visits to check on patients including at evenings and the weekend.

Areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The practice offered a wide range of specialised clinics and the practice had reached out to the local community by approaching community events, churches and schools and had attended them to promote better health. If any underlying health issues were identified the patients were offered an appointment at the practice and patients from other practices were advised to attend their own GP.
- The practice had identified 500 patients where clinical indications to offer medication to reduce cholesterol. They initiated and offered extended appointments to explain benefits of and risks from that medication. They engaged in collaboration with the University of Cambridge Primary Care department to undertake this as a research project of patterns of take up. The results are awaiting publication by a peer reviewed international clinical journal
- The practice has an extremely engaged and active patient participation group with over 800 members participating remotely as well as regular face to face to engagement. We saw examples of the PPG being able to influence practice behaviour to benefit patients.

Firs House Surgery

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 CQC inspector and a practice nurse specialist advisor.

Background to Firs House Surgery

The Firs House Surgery is situated in Impington, Cambridgeshire, with a branch practice at Cottenham, Cambridgeshire. The practice is accessible by public transport (bus and train). The practice is one of 107 GP practices in the Cambridge and Peterborough Commissioning Group (CCG) area. The practice has a general medical services (MS) contract with the NHS. There are approximately 11400 patients registered at the practice. The practice undertakes a range of specialist clinics including minor surgical procedures.

The practice has six partner GPs, one associate GP and one salaried GP. One GP is designated as the senior partner. All partner GPs have lead responsibilities and management roles. There is a mixture of male and female GPs. The practice is also a training practice and trainee GPs work there on a short term basis carrying out consultations under the supervision of one of the partner GPs. There is currently one trainee at the practice.

The GPs are supported by a senior nurse, three further nurses, one health care assistant and two phlebotomists. There is a practice manager and assistant manager, lead receptionist and a number of support staff who undertake various duties. There is a reception manager and a team of receptionists. All staff at the practice worked a range of different hours including full and part-time.

The surgery is open from 8am until 6pm.The practice did offer appointments in the evenings, earlier morning and at some weekends dependant on demand. Surgeries run in the mornings and afternoons each day. The practice has opted out of providing 'out of hours' services which is now provided by another healthcare provider. Patients can also contact the emergency 111 service to obtain medical advice if necessary.

There has been no information relayed to us that identified any concerns or performance issues for us to consider an inspection. This is therefore a scheduled inspection in line with our national programme of inspecting GP practices.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to and during our inspection we spoke with representatives of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We also spoke with representatives from two of the care homes that were provided with GP services from the practice.

We carried out an announced inspection on 30 June 2015 at the practice. During our inspection we spoke with a number of GPs, the practice manager, a senior nurse, nursing staff, administrative and reception staff. In addition we spoke with patients, two members of the patient participation group and we observed how patients were cared for. We reviewed 21 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Incidents, accidents and national patient safety alerts, as well as comments and complaints received from patients were reviewed appropriately and learning was shared across practice staff. The staff we spoke with were aware of their responsibilities to raise concerns and they knew how to report incidents and near misses. National patient safety alerts were disseminated appropriately and GPs we spoke with were able to give examples of alerts they had recently acted on. We reviewed safety records, incident reports and minutes of meetings where safety was discussed. We looked at records from a two year period, this showed the practice had managed these consistently over time and so could demonstrate a safe track record. An example of this was a review carried out by the practice on recording information from carers requesting home visits; a new system was in place to assist effective communication.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 17 significant events that had occurred during the last two years and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every month to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. We saw a spreadsheet that was colour coded to highlight priority and named staff responsible for each event resolution. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

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

Reliable safety systems and processes including safeguarding

The practice had a safe system to manage and review risks to vulnerable children, young people and adults. For example training records showed that all GPs and nursing staff had completed safeguarding training for children and adults. All the administrative staff had also completed safeguarding training in respect of adults.

All staff we spoke with were aware who the lead GP was in relation to safeguarding and who to speak with if they had a safeguarding concern. The lead GP attended safeguarding update meetings and met with health visitors every four to six weeks to discuss individual cases. Every six months the lead GP met with school nursing staff to discuss safeguarding best practice involving school age children. We saw computer records with the alerts system for safeguarding displayed and we saw evidence of safeguarding being discussed within the clinical practice meeting.

There was a chaperone policy, which was visible on the waiting room noticeboard, in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take

in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated on various dates according to issue, the last one being in May 2015. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. We saw evidence of a risk assessment process and paperwork the prescriber used to ensure that procedures were carried out for each patient.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. As an example the lead nurse conducted spot checks on clinicians using equipment to check on hand cleanliness. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury, a précis of this policy was also displayed in surgeries.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

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

Equipment

Staff we spoke with told us they had 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 which was 31 January 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. 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 the appropriate checks through the

Good

Are services safe?

Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements

There was an extensive induction procedure in place and we saw an example of this being followed from start to the completion of a probationary period. This procedure had three and six monthly interviews, a nominated tutor and competency areas to achieve. On the example we checked these were all completed and countersigned by a named tutor.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, electrical installations and fixtures. We saw the practice had a health and safety policy and staff told us they were aware of its contents.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health or medical emergencies. For example medical emergencies were responded to by the most appropriate team on duty at the time. There was an electronic method of summonsing assistance from other clinical teams. We saw appropriate emergency medicines were in place and the equipment they would use to respond was within expiry dates.

Records we reviewed showed all staff had received training in basic life support and cardiopulmonary resuscitation (CPR). Emergency medical equipment was available including access to oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).All staff we spoke with knew the location of this equipment and records we reviewed confirmed it was checked regularly. The disposable items which were necessary for the safe use of both the oxygen and AED were in date and fit for purpose. These are delivery masks and tubing in the case of Oxygen and disposable pads in the case of the AED. Emergency medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia were all available in a secure area of the practice. Appropriate arrangements were in place to ensure emergency medicines were within their expiry dates and suitable for use.

Arrangements to deal with emergencies and major incidents

We saw a business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified risks such as unplanned staff absences, adverse weather, loss of electricity and water supply. The mitigating actions for each risk were recorded to ensure staff were aware of how to manage risks. The plan also contained relevant contact details for staff to refer to. These included local health services and contact details for companies providing utilities such as gas and electricity.

The continuity plan we reviewed showed the practice had carried out a fire risk assessment in October 2014. The assessment detailed fire hazards within the practice, the risks and actions required to maintain fire safety. For example all staff had received fire awareness training and were familiar with fire evacuation procedures. Regular maintenance and testing of mobile and fixed fire equipment was also undertaken and this had been completed in February 2015. There was evidence of annual servicing of the fire alarm system and fire extinguishers as well as weekly fire alarm tests; these were by the administration and nursing staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We saw that GPs led in specialist clinical areas such as dermatology, cryotherapy, minor surgery, diabetes, diet clinic, asthma, travel, mental health and family planning. Clinics were held at the practice, in all of these areas at various times of the month dependant on demand. For example the nurses held travel clinics twice a week with the support of GP's, this meant patients were able to receive advice and medication prior to travel without extended travelling to a setting some distance away. There were extensive medications available including those normally available in more specialist settings for example Japanese Encephalitis**. (A vaccination for a disease that is** spread through the bite of an infected mosquito).

We saw evidence of where GPs sought a second opinion which had the effect of reducing the number of secondary referrals. We spoke with GPs' and nurses' and were told that staff met every day and informally discussed cases. We also saw records of formal meetings where patients that had been referred for secondary care were discussed. These meetings were held each week. We saw a record of one meeting where 27 patients were discussed and decisions and pathways challenged. This allowed for alternatives to be discussed and two of these patients were offered alternative care plans; this reduced the impact on patients by restricting travel and value for money as more appropriate services were offered locally.

We found the practice worked towards the gold standards framework for end of life care and maintained a palliative care register. Records reviewed showed that regular multi-disciplinary meetings were held to discuss the care and support needs of these patients and their families. The meetings were attended by the GPs and community matron and for example dealt with any patients recently discharged from hospital so they were assessed according to need.

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

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 information staff collected was then collated to support the practice to carry out clinical audits and improve the service.

We found clinical audit work informed the GPs' prescribing practice to ensure they were offering care and treatment in line with best practice guidelines. Records were maintained to show how they had evaluated the service and documented the success of any changes. We reviewed data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was in line with expectations and showed no anomalies.

The practice showed us five clinical audits that had been undertaken in the last year. We saw audits of referral rates for coil insertion and rejection, dermatology referrals, management of gout and two diabetes based reviews. We saw evidence that the practice was completing reviews after these audits and repeating them to identify the benefit to patients.

We saw an example of good practice where the GPs' had identified they had a group of patients where there was clinical indications to offer a course of medicine to help to lower cholesterol. The practice identified a need to research patients' choices when offered a thorough explanation of the potential benefits and risks. We saw evidence of a clinical trial of over 500 patients and this trial

Good

Are services effective?

(for example, treatment is effective)

has been accepted by Cambridge University for potential publication. There were immediate benefits to the patients concerned as they were offered a comprehensive service and potential wider benefits for the medical community.

The practice had a repeat prescribing policy in place which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

The practice was in the process of moving to electronic prescriptions which allow patients greater flexibility.

The practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards

practices for managing some of the most common long-term conditions and for the implementation of preventative measures. For example; the percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years was measured at 82.99% for the practice. The national figure for the same indicator being 81.89%.The practice met all the minimum standards for QOF in asthma, cancer, epilepsy and chronic obstructive pulmonary disease (lung disease), but did only achieve an overall score of 71% whilst the national average was 93.5%. The practice participated in a local quality scheme over January to March 2014. This was offered by the NHS England area team who reduced the level of QOF monitoring during the period. These changes have resulted in the data submitted by the practice to the area teams and Health and Social Care Information Centre (HSCIC) being lower than expected.

The practice made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support, information governance, safeguarding vulnerable adults and children. Records we viewed reflected that staff training was being monitored effectively.

We found the practice was committed to staff development and had an appraisal policy in place to encourage the evaluation of learning needs and monitor performance. All staff received annual appraisals that identified learning needs from which action plans were documented. The action plans were then used to assess a staff member's progress in achieving the targets and objectives that had been set for them. Our interviews with staff confirmed the practice was proactive in providing staff training. The practice had supported staff to undergo further training and to increase their skill levels; one of these staff being clinical and the other administrative.

The practice was a GP training practice and had a named GP responsible for mentoring GPs in training. The practice also conducted training internally and showed how they progressed their health care assistants so they were competent in a number of areas, such as giving vaccinations.

GPs were up to date with their annual continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation

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

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex requirements. It received blood test results, X ray results, letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice demonstrated good care by a named GP being responsible each day for the receipt and interpretation of incoming test results. The GP personally telephoned

Good

Are services effective?

(for example, treatment is effective)

patients with abnormal results; this enabled the patient to ask any questions direct to the GP avoiding any communication or delays. The duty GP also telephoned the patients of any other GP that was not on duty that day and passed results to those that were in the practice so they could speak with their own patients.

We saw an effective culture of sharing information via the intranet within the practice and staff we spoke with were able to explain how this took place. For example one GP was able to describe to us how they were updated with current guideline changes. The weekly practice meeting had standard agenda items which demonstrated this culture.

The practice held monthly multi-disciplinary team meetings to discuss the needs of patients with complex needs, for example those with end of life care needs or children on the 'at risk' register. These meetings were attended by the community matron and palliative care nurses, as well as GPs. We saw that decisions about care planning were documented in a shared care record. Staff we spoke with told us that this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We also saw there were mechanisms in place to share information with 111(out of hours telephone advice) services. These enabled special notes to be placed on patient's files, for example with regard to safeguarding or palliative care.

We saw an effective range of internal meetings to share information and these included quarterly full practice, weekly management, monthly rota, monthly MDT meetings and safeguarding every four to six weeks.

Information sharing

The practice used several electronic systems to communicate with other healthcare providers. This included the electronic summary care record which was fully operational at the practice. Summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours setting.

We saw an electronic system that allowed a special notes system to be added to the patient's notes to give GPs and other healthcare professionals' further information on patients, explaining some aspects of their care. We looked for example at a patient receiving end of life care where the special note was used to give contact details of the GP to be used up to midnight daily so they could provide continuity for the patient. This in effect meant the family had a known GP as contact in the event they needed further support during the evening.

The practice had an electronic system to allow patients to use a "choose and book" system. This allowed patients to look at appointments when being referred to secondary care and to choose a location, time and day that suited them best. Staff we spoke with said this system worked well and reduced cancelled or non-attendance for appointments.

All staff we spoke with were fully trained on the electronic systems and were able to demonstrate effective use of all its functions.

We saw that the practice manager had developed an intranet that contained a large amount of information. For example it contained a secure area for staff information, training updates, journals, surveys, patient feedback, NICE guidelines and further clinical data. All staff we spoke with knew how to use this system and it had been adopted by other practices in the CCG.

Consent to care and treatment

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

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

All clinical staff had a clear understanding of Gillick competence. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. As an example for all minor surgical procedures, written consent was obtained and a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and

complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, the percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken was 100% with the CCG average being 92.8%.

We saw evidence that the GPs thoroughly engaged with the community in respect of health promotions and awareness. For example a GP was booked to attend a community event where in excess of 2000 people were due to be present. There was an ability to conduct health checks and clinical observations free of charge whilst promoting health advice. This included diet, weight and lifestyle changes to improve health. There were over 120 health lifestyle quizzes carried out by people and appropriate advice given dependant on the result.

We saw evidence of GP's organising community talks in local facilities. They gave lectures to the community of lifestyle choices effecting health and brought in expert speakers to reinforce the messages. We saw an extremely wide range of written material in the waiting rooms to inform the patients regarding health initiatives and places to go to gain further insight. We noted over 110 different pieces of information in the surgery offering all patients options and information.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 780 patients had been eligible and offered a health check. 52% of patients in this age group took up the offer of the health check. We were shown the process for following up patients within 2 weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice's performance for the cervical screening programme was 83%, which was above the national average of 81.9%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example: Childhood immunisation rates for the vaccinations given to under twos ranged from 92% to 97% and five year olds from 87% to 97%. These were above CCG averages.

The practice conducts travel clinics and had an opinion that they wanted patients to have access to Hepatitis B vaccinations but some patients had told them the cost was prohibitive. They took steps to make the vaccination free to patients and told them that was the case. We saw that between June 2014 and June 2015 the practice saw 369 patients in the travel clinic and 297 of those had received the Hepatitis B vaccination.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with ten patients on the day of our inspection who told us they received a very good service. These patients told us they were satisfied with the care provided, and said their dignity and privacy was respected. We observed positive interactions between staff and patients.

Patients also completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Most patients commented that the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive and this was concerning the availability of appointments for working patients. We spoke to a representative from the PPG about this and were told this issue was less of a problem as the practice had changed its appointment system.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national GP patient survey and the practice's own survey for 2013/14. The evidence from all these sources showed patients were satisfied with how they were treated. For example 99% said were able to get an appointment to see or speak to someone the last time they tried with the national average figure being 85% and 98% had confidence and trust in the last GP they saw or spoke to with the national average being 95%. 100% of respondents had confidence and trust in the last nurse they saw with the national average figures being 97% and 88% said GPs gave them enough time during consultations with the national average being 87%.

Patients we spoke with said they would have no hesitation in recommending the practice and this was also apparent from the national GP patient survey where 89% of patients said they would recommend the practice with the national average being 78 %.

Staff and patients told us that all consultations and treatment was carried out in the privacy of a consulting room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

There was a clear sign on reception that asked patients to respect others and allow conversations in private and the reception was contained in a separate room to the waiting areas. If a confidential matter needed to be discussed patients could be taken into a separate room to maintain their privacy. We found that reception staff used a quiet tone to avoid being overheard as much as possible. There was a touch screen available to avoid the need to speak on arrival and this was in an easily accessible location.

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, making decisions about their care and treatment; the surveys generally rated the practice well in these areas. For example, the 2015 national GP patient survey data showed 88% of practice respondents said the GP involved them in decisions about their care compared with the national average of 81% and 96% felt the GP was good at explaining tests and results compared with a national average of 86%. 95% said the last nurse they saw or spoke to was good at explaining tests and treatments compared with the national average of 90% , and 89% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared with the national average of 85%.

The patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff, and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also aligned with those views.

Patients had access to online and telephone translation services for those patients whose first language was not English. Staff told us they worked together with patients to ensure they were partners in their own care, particularly patients with long term conditions, those with mental health needs and those receiving end of life care.

The practice had received an award from the Clinical Commissioning Group in January 2014 in recognition of its

Good

Are services caring?

work to support unpaid, informal and family carers through the family carers' prescription. This is an award winning incentive to support carers and provide breaks and on-going support.

Records reviewed showed monthly multi-disciplinary meetings were held to discuss the care needs and support required for patients on the palliative care register, as well as with their carers who were involved in any decisions made.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, some patients told us they had received help to access support services to help them manage their physical and mental well-being. The comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website informed patients how to access a number of support groups and organisations. These included carer's direct, improving access to psychological therapies and bereavement. A system was in place to notify staff of bereavements so they could offer support to relatives when they attended the practice. The GP then based their response on individual cases and would either write or call the family of the deceased.

Staff told us that if families had suffered bereavement, their usual GP contacted them by giving them advice on how to find a support service. This call was followed by a patient consultation at a flexible time and location to meet the family's needs.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice provided funds to financially support a community mini bus that collected patients with reduced mobility and conveyed them to the practice to be seen. We were told that up to 50 patients per month benefited from this service and they were able to gain access to appointments that otherwise would have been difficult.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example they maintained a register of over 150 patients from the travelling community. These patients were maintained on the register despite not always being in the local area. The practice met with a nurse who acted as a liaison between the practice and the community, we saw evidence of how this had broken down barriers and enabled access to services such as for those patients who were illiterate. The practice was supporting the community to obtain a European Union grant to improve sanitation and promote better health. The practice had also engaged with the clergy together with the traveller liaison nurse; we were told this was beneficial to patients and assisted communication. For example the priest was assisting breaking down barriers and assisting the practice to access patients with mental health issues from the travelling community. We spoke with the traveller liaison nurse who told us that the practice was using every means possible to engage with the groups and was always willing to listen and implement new ideas. For example the community had identified a need to explain written documents as they had difficulty understanding written documents. This had been noted on individual patient records and documents such as prescriptions were read through to check the patient understood.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We saw a board in the waiting room titled "you said, we did" this outlined 15 areas for improvement suggested by the patient survey and PPG that had been acted upon; for example doctors waiting times and appointment availability. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on two levels but there was always an option for patients to be seen on the ground floor. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice engaged with a local group supporting patients with dementia and those who cared for them. Regular meetings were organised and reception staff had received training in assisting patients with a reduction in their level of capacity. We saw evidence of bespoke meetings with dementia liaison teams from outside of the practice together with regular meetings were they were involved. We saw a register of patients with dementia and special notes on their patient records and also those who were carers.

We spoke with the managers of two nursing homes where the practice performs visits and both managers described the described their relationship with the practice as "exceptional". Both managers had a named GP who attended the care homes as much as twice daily, they described regular meetings to discuss patients, monthly medication reviews and the patients having a personal service from the GPs. One of the managers also stated that one GP had attended the home in the evenings and at weekends when there was concern for a patient. This had not been as a result of a request but a spontaneous visit to see if help was required.

Access to the service

The surgery was open from 8:00 to 6:00 Monday to Friday. There was also an extended hour's system available should patients need to see the GP.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to five local care homes on a specific day each week, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 86% described their experience of making an appointment as good compared to the national average of 73%.
- 99% said they were able to get an appointment to see or speak to someone the last time they tried. This compared with a CCG average of 88% and a national average of 85%.

78% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%. This data was collected from the patient survey 2014/2015. The practice had reviewed information from the 2013/2014 survey and modified the appointment process by adding additional lines and staff. We saw an increase in the level of patient satisfaction between the two surveys. The patients we spoke with also stated this had made a difference and their experience of making an appointment much improved.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. For example, a patient told us he had requested to see a GP as he was feeling unwell. He was seen by a GP within 30 minutes and referred directly to hospital.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated person who handled all complaints in the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practice. We saw that information was available to help patients understand the complaints system. This included posters displayed within the practice, patient leaflets and information on the practice website.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. We also saw minutes of meetings where the complaints and compliments had been shared with the patient participation group and discussed in order to identify areas for improvement. These had been appropriately sanitised prior to release to protect patient confidentiality.

We looked at complaints received in the last 12 months, there had been eight recorded complaints since April 2014 and we found they were satisfactorily handled and dealt with in a timely way. Staff we spoke with told us of an open and transparent culture which was promoted when dealing with complaints.

Minutes of team meetings showed that complaints were discussed with all staff to ensure they were able to learn and contribute to determining any improvement action that might be required. For example GPs had been given feedback from a complaint where delays had been experienced in a secondary referral. We reviewed the complaints and found the vast majority were in relation to the appointments system originating from high demand and staff shortages.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and three year business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas, reception, all surgeries and in the staff room. The practice vision and values were comprehensive and fully engrained into practice ethos and behaviour. These included maintaining high quality care though continuous learning and training, acting with integrity and confidentiality, continually improving and working effectively with the wider community health services.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. There was an electronic storage system where staff could access the information they needed whilst restricting certain confidential information to nominated staff. We looked at these policies and procedures, and all staff had completed a cover sheet to confirm that they had read and understood the policies. All of the policies and procedures we looked at had been reviewed and were up to date, staff we spoke with knew where to find these policies if required.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The practice used the Quality and Outcomes Framework (QOF) to measure its performance but had only partially used the outcomes for three months of 2014. This was due to a local CCG initiative to change measurements. The practice kept an over-view of QOF as it gave important clinical dates and measurements for patients but the measurements available for the period of three months were inaccurate. We saw evidence the practice used this information to the benefit of patients and the practice acted in their best interests. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. A nominated GP was responsible for monitoring aspects of the QOF data supported by the practice manager.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example management of gout, diabetes, asthma and rejection rates for inter uterine coils. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

We saw evidence of learning from the other audits that had been carried out. Conclusions had been reached and learning disseminated throughout the clinical staff. An example was improved follow up for patients with intra uterine coil inserted.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example patient waiting times and GP availability. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. In addition to full staff meetings there were partner meetings, district nurse meetings, a meeting to specifically look at significant events and clinical governance meetings every four months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we

Are services well-led?

Outstanding ☆

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

spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every four weeks. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held every 12 months and in addition held quarterly half day closures of the practice for training and development. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

We saw evidence that the GPs' took ownership of daily priorities and the whole team felt valued and there was an inclusive team atmosphere. An example of this was the duty GP for the day would attend the reception area each day when the telephone lines opened. They would look at the appointments available for the day and change the daily activity of the GPs if it was felt there were not enough appointments available. The staff we spoke with expressed an opinion of how this made them feel valued and enabled them to open enough appointments available for the day. On the day of our inspection this had happened and at midday there were still 15 appointments available for that day.

The lead receptionist sends out an internal email to all staff each day at 8am. This outlines all staff on duty, any specialist clinics available for the day, any special events for the day, activity and staff at the branch practice and any other item effecting practice performance. We spoke with staff that identified this as helpful and enhanced feelings of team working.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups; including young families, the elderly and the practice were actively trying to encourage student membership. We saw a very active PPG that meets regularly with approximately 15 patients in attendance and saw the membership of the virtual PPG at over 800 patients. A virtual PPG is one where the participants take part using electronic media such as email and the internet rather than in person.

The PPG had carried out quarterly surveys and met every two months. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with 2 members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We saw evidence of on-going engagement with the PPG where they were able to influence the activities of the practice, we saw the "you said, we did" board in the waiting room with 15 areas of feedback and action. We also spoke to a member of the PPG who proof reads the quarterly practice newsletters to ensure it is patient friendly. We also saw a range of activities that the PPG undertook in the community together with the GPs. For example a community event where the PPG had a stall and GPs attended to speak about the practice and joint working. We saw evidence of meetings within the parish where there was joint input from both the PPG and GPs promoting health.

We also saw evidence that the practice had reviewed its' results from the national GP patient survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around

Are services well-led?

Outstanding ☆

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

travel immunisation at their appraisal and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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.

The practice was a GP training practice and regularly had a training GP present and being tutored.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example they identified a patient where a patient had been released from hospital and not reviewed at the practice; new procedures were put in place to ensure that happened in future.

The practice closed quarterly for one afternoon to perform staff training and updates, we saw evidence of this training and external providers were invited to give input. Examples of these were dermatology, key points for cancer care, the Mediterranean diet, diabetes and mental health.