Attleborough Surgeries

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Attleborough Surgeries have a practice population of approximately 17400 patients for Attleborough town and outlying villages. We carried out a comprehensive inspection at Attleborough Surgeries on 5 November 2014. Although Attleborough is the primary location patients could choose to be seen at Queens Square Surgery. Both these sites are registered with the Care Quality Commission (CQC) as one location. Both venues offer medicine dispensing services for patients who lived in excess of one mile from a pharmacy. We inspected Attleborough, we did not visit Queens Square Surgery.

We have rated each section of our findings for each key area. We found that the practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because the practice staff were well organised which, led to an efficient service provided by motivated staff. Each senior member had dedicated roles. There was a written 'practice plan' dated 2014 to 2015 that described the services provided, the challenges and what actions senior staff planned to take to overcome them.

Our key findings were as follows:

- We found evidence that the practice staff worked together to make on-going improvements for the benefit of patients.
- Each day there was an assigned duty doctor to respond to any unexpected peaks in patient requests to be seen and to deal with other tasks on behalf of GPs who were on annual leave.
- The practice was able to demonstrate a good track record for safety. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.
- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were satisfied with the care they received.

We saw an area of outstanding practice:

- As well as a Patient Participation Group (PPG) there was a patient reference group (PRG) of approximately 500 who were communicated with via email. This was set up to capture opinions from younger patients and patients who may work or be at home with children.

Summary of findings

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

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learnt 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 employed to keep people safe. Patients were protected against the risks associated with management of medicines for storage, use and handling and dispensing of medicines.

Are services effective?

Good

Clinicians were up-to-date with both the National Institution for Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other professionals to ensure patients received effective care that was tailored to their needs. Practice staff carried out clinical audits and as a result made changes where necessary to promote effective care for patients. Systems were in place for regular reviews of patients who had long term conditions and housebound patients.

Are services caring?

Good

Patients said they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff ensured patient confidentiality was maintained. Accessible information was provided to help patients understand the care available to them. We observed that staff interacted with patients in a polite and helpful way and they greeted patients in a friendly manner.

Are services responsive to people's needs?

Good

The practice demonstrated how they listened to and responded to their patient group. We saw that efforts had been made to reach out to each population group to ensure they received appropriate care and treatments. There was a system in place which supported patients to raise a complaint. Complaints received were recorded, investigated and responded to in a timely way. The layout of the premises supported access for patients who had restricted mobility.

Summary of findings

Are services well-led?

Good

The practice had an annual 'practice plan' which was reviewed quarterly to monitor progress against the objectives. The GPs provided care and treatment to people who resided in eight care homes. Each partner had dedicated lead roles such as; palliative care, clinical governance, research and prescribing. Analysis of incidents, serious events and complaints were completed in order to minimise the risk of further occurrences. Senior practice staff sought feedback from patients, which included the patient participation group (PPG) and the patient reference group (PRG). From this improvements had been made such as; a booklet informing patients about the appointments system.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

Twenty percent of the patients were aged over 75 years. All patients aged 75+ years have a named doctor who is accountable for their care. There was a named GP for each of the care homes in order to build better relationships with patients and care home staff. Practice staff liaise closely with the community frail elderly team who, also regularly attend practice meetings to ensure the care for these patients is up to date in meeting their needs. The practice provides a free medicine delivery for patients who are housebound.

People with long term conditions

Good

The practice holds a register and a re-call system when patients were due for a review for those with long term conditions. A practice nurse specialised in long term conditions and diabetes provides updates at clinical meetings relating to management guidelines for this patient group. The practice staff arrange specialist outreach appointments where these were deemed to be appropriate. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

Families, children and young people

Good

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice staff worked with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. Alerts and protection plans were in place to identify and protect vulnerable children.

Working age people (including those recently retired and students)

Good

The practice offered extended opening hours. These were appointments from 7am each Tuesday and from 7:30am Fridays. Patients could also be seen between 6pm and 8pm on Wednesday evenings. Patients were offered choices when they were referred to other services.

People whose circumstances may make them vulnerable

Good

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. Practice GPs provided a service for patients with learning disabilities who lived in two care homes. The practice had carried out annual health

Summary of findings

checks for people with learning disabilities. These patients were sent a letter asking them to attend for a review. The letter had been produced in pictorial format to assist this patient group in understanding what they needed to do. Practice staff recently held a meeting with the learning disabilities nurse to discuss ways of supporting those who had failed to attend for their reviews.

People experiencing poor mental health (including people with dementia)

Practice GPs provided a service to a small care home for patients with mental health disorders who had been detained under the Mental Health Act. Care was tailored to patients' individual needs and circumstances including their physical health needs. Annual health checks were offered to patients with significant mental health illnesses. Doctors had the necessary skills to treat or refer patients with poor mental health.

Good

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection who varied in age. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all reported they were happy with the standards of care they received. We were told it was easy to obtain repeat prescriptions. Two patients told us it was getting harder to make appointments; other patients said they were satisfied with the appointment system.

We collected 11 Care Quality Commission comment cards from a box left in the surgery prior to the inspection. Nine comments made were very positive. The comments included staff efficiency and how professional they were and good standards of care. A patient who had a wrist injury expressed their dissatisfaction that practice staff did not arrange transport for them to attend the hospital the following morning.

The Patient Participation Group (PPG) had carried out an annual survey. PPG's are an effective way for patients and surgeries to work together to improve services and promote quality care. The outcomes in the report dated 2014 to 2015 were positive. The report contained the comments that patients had made and any recommended improvements that could be made. We spoke with the chair of the PPG who told us that the management team liaised well with the group to look at ways to further develop and improve the service patients received.

Outstanding practice

As well as a Patient Participation Group (PPG) there was a patient reference group (PRG) of approximately 500 who were communicated with via email. This was set up to capture opinions from younger patients and patients who may work or be at home with children.

Attleborough Surgeries

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 and a Specialist Advisor who had experience in practice management.

Background to Attleborough Surgeries

Attleborough Surgeries have a practice population of approximately 17400 patients for Attleborough town and outlying villages.

At the time of our inspection there were five GP partners at the practice and three salaried GPs. The GP's provided 60 sessions per week and a further 8 sessions will be provided from January 2015 when a new partner commences working at the practice. Attleborough Surgeries is a training practice for first year and final year medical students. There was a practice manager, reception/surgeries manager, IT manager, dispensary manager and a nurse manager who was a nurse practitioner. There were two more nurse practitioners, five practice nurses, five health care assistants and nine dispensing staff who were employed to work varying hours. Non-clinical staff consisted of eight administrators, 12 receptionists and four other staff with specific roles who were employed to work varying hours.

The practice offered a range of clinics and services including chronic disease management, cervical smears, contraception, minor surgery, injections and vaccinations. A nurse practitioner specialised in diabetes, chronic obstructive airways disease, family planning and contraception. Practice staff provided advice to patients about healthy living and smoking cessation.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired)

Detailed findings

- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 November 2014. During our visit we spoke with a range of staff including two GP's, two nurse practitioners, a health care assistant, the practice manager, dispensing manager, reception manager, and a receptionist. We also spoke with eight patients who used the service and chair of the Patient Participation Group (PPG) who acted as patient advocates in driving up improvements. We observed how people were being cared and how staff interacted with them and reviewed personal care or treatment records of patients. We reviewed 11 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 had named health and safety and infection control leads. Practice staff demonstrated that there was a good track record for safety. We saw records to show that performance had been consistent over time and where concerns had been identified these had been addressed in a timely way. The practice manager showed us there were effective arrangements that were in line with national and statutory guidance for reporting safety incidents. The practice manager took incidents into account when assessing the overall safety record.

There were clear accountabilities for incident reporting, and staff were able to clearly describe their role in the reporting process. We saw how the practice manager recorded incidents and ensured they were fully investigated. The GPs held regular meetings to review safety within the practice to ensure all relevant actions had been taken.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events. Staff made the recordings as soon as possible when concerns were identified.

We saw evidence that learning from incidents was shared with staff in a timely and appropriate way in order to reduce the risk of a similar occurrence. The practice staff also notified the local Clinical Commissioning Group (CCG) of specific events. The CCG is the NHS body responsible for commissioning local NHS services.

We were given some sample significant event audits. These clearly stated the investigations carried out, the resultant actions and which staff the information had been cascaded to. The records we saw told us they had been completed appropriately.

Reliable safety systems and processes including safeguarding

Practice staff had written policies and systems in place to ensure that patients were safeguarded against the risk of abuse. There was a named GP lead for safeguarding and we saw that all staff had received training appropriate to their role. Effective safeguarding policies and procedures were in place were fully understood and staff knew where to access them. There was close co-operation with local health visitors which helped to identify children at risk and keep them safe.

There was a chaperone policy available to staff and posters were on display in the clinical rooms. When chaperoning took place this was recorded in the patient's records. Clinical staff carried out chaperone duties, reception staff, dispensing staff and some administrators had been trained for chaperoning. We asked a receptionist how they would carry out this duty. They demonstrated they would chaperone patients in a safe way.

Medicines Management

We found that medicines management was safe. Repeat prescriptions could be requested on-line, by post or by leaving the repeat request tear off slip at the practice. The patient leaflet stated that it took two working days for the medicines to be ready for collection. The patients we spoke with told us there was no delay in getting their prescriptions.

The dispensary manager showed us the whole process for dispensing prescribed medicines. Prescriptions for non controlled drugs were not signed by a doctor before the medicines were dispensed. Senior staff had put a system in place to commence on 24 November 2014 that would ensure prescriptions were signed before they were dispensed. To prevent errors from occurring a second dispenser checked that all medicines had been dispensed correctly.

Any errors or incidents were recorded and some had been escalated as significant events for full investigation and where appropriate action had been taken to prevent recurrences. This demonstrated that staff had learnt from errors and incidents.

Audits in relation to medicine management practices had been carried out. Where improvements were identified staff had put systems in place to address them.

The key to the controlled drug (CD) cabinet was kept in a safe place. Checks on the CD's were carried out every week and every three months by a GP. We found that the CD's were safely stored and dispensed safely and the recordings were appropriate.

Good

Are services safe?

The drug fridge temperatures had been recorded each day and were kept within normal limits as per manufacturer's guidance to ensure medicines remained stable and fit for administration.

Emergency equipment and medicines were stored safely and regularly checked to ensure they remained in date and fit for use.

One doctor had their own visit bag. We were shown the audit tool that the dispensary manager used when they audited the medicines in each bag. This ensured the medicines remained in date and were safe for administration.

Cleanliness & Infection Control

We looked at how infection prevention and control was managed at the practice. We spoke with a nurse practitioner who was the lead for infection control. They told us they had recently attended a two day training course that was Royal College and Nurses (RCN) accredited. The nurse practitioner carried out full audits of the practice every six months. Where improvements had been identified actions had been created within the report. For example, staff were not signing the sharps bins but this had been addressed. During November 2013 the nurse practitioner carried out update sessions with staff and tested their hand washing techniques.

We saw that there was a cleaning schedule in place for cleaning staff to follow. The nurse practitioner told us they carried out spot checks on the hygiene levels within the practice. They told us there was a communication book that was used to inform the cleaning staff of any necessary tasks. Computers and medical equipment was cleaned by nurses and health care assistants. We saw that Control of Hazardous Substances Hazardous to Health (COSHH) data sheets were in place to advise staff how to safely handle all cleaning products.

As part of the infection control process the practice staff held records of clinical employee's hepatitis B vaccination status. This was needed because these staff routinely came into contact with blood products.

Legionella risk assessments had been carried out to protect patients and staff from unnecessary water borne infections.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and appropriate recordings maintained.

Staffing & Recruitment

Senior staff based the staffing requirements on its experience of how the practice operated. Consideration had been given to the care and treatments that patients required. We asked how staffing shortages were managed across all grades of staff. The practice manager explained that a large number of staff worked part time and were willing to work extra shifts to covers staff holidays. There were occasions when locums were used to cover GP absences.

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

Monitoring Safety & Responding to Risk

There was a fire safety risk assessment in place. Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency.

The emergency lighting had been tested monthly and actions taken where defects found. Risk assessments of work stations had been carried out. We saw that fire escape routes were kept clear to ensure safe egress for patients in the event of an emergency.

There was a health and safety policy in place and staff knew where to access it.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

We saw a copy of the business continuity plan. It included the contact details of services that could provide emergency assistance. The practice manager and all partners kept a copy of the document at home to ensure there was access to it in any eventuality.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used the National Institute for Care and Excellence (NICE) guidance to ensure the care they provided was based upon latest evidence and was of the best possible quality. We saw that any revised NICE guidelines were identified and shared with all clinicians appropriately.

The clinicians we spoke with confidently described the processes to ensure that informed consent was obtained from patients whenever necessary. They were also aware of the requirements of the Mental Capacity Act (MCA) 2005 used for adults who lacked capacity to make informed decisions.

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

Management, monitoring and improving outcomes for people

Practice staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care. We were shown the latest QOF achievements that told us practice staff were meeting all of the national standards.

Practice staff had a system in place for carrying out clinical audits. One audit concerned a review of the use of a medicine and the actions that had been taken as a result of the audit. A comparison had been made with the rate the medicine was prescribed against the use by other practices within the locality. The respective GP had provided a list of all patients who were prescribed the medicine with a request that they should be reviewed to check if the patients still required the medicine and the dosage. Another audit concerned the possible interactions when two medicines were prescribed. The results were discussed during a clinical meeting to raise awareness of the results.

The audit had been scheduled to be repeated one year later. We were shown a list of the audits that had been carried out and dates recorded of when the audits would be repeated.

GPs held regular clinical meetings. The minutes from 1 and 22 October 2014 informed us patient care, significant events, complaints, safeguarding and the dispensing of medicines had been discussed. The recordings included learning from errors. Management issues were discussed at weekly partners meetings and patient care such as child flu vaccinations.

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 the training courses such as annual basic life support. All GPs had completed their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff had annual appraisals which identified learning needs from which action plans were documented. We saw that nurse's appraisals and dispensing staff appraisals were carried out by clinical staff so that their practices could be discussed and checked. Where poor performance was identified a programme of training and supervision was put in place. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example specialist diabetes training for one of the nurse practitioners.

Working with colleagues and other services

There was evidence of appropriate multidisciplinary team working and it was apparent there were strong relationships in place. A multidisciplinary meeting was held every month to discuss patients receiving end of life care and those considered to be at risk. Community staff attendance included Macmillan nurses, the community matron and district nurses. Regular contact was also maintained with health visitors so that children considered to be at risk were appropriately monitored.

Good

Are services effective?

(for example, treatment is effective)

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and diabetes.

Patients were invited to contact the practice to receive their test results. However, if a test was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system included a facility to flag up patients who required closer monitoring such as children at risk.

For patients who had attended an out of hours service or following discharge from hospital we were told that the respective GP (or the duty GP if the designated GP was not available) reviewed the information provided to them on a daily basis. A GP told us that if patient's required follow up they would send a request to the patient for them to make an appointment. If necessary a referral would be made to a hospital or physiotherapist.

Consent to care and treatment

We spoke with eight patients and they all confirmed they felt in control of the care because they had been well informed about their illnesses and treatment options. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure. We were told that consent forms were signed only after full explanations had been given to patients.

GPs were aware of the requirements within the Mental Capacity Act (MCA) 2005. This was used for adults who lacked capacity to make informed decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

They also knew how to assess the competency of children and young people about their ability to make decisions about their own treatments. Clinical staff understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged less than 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

The practice manager told us all new patients were offered a health check and a review of any illness and medicines they were taking.

Patients who were due for health reviews were sent a reminder and if necessary contacted and asked to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information leaflets in the waiting area for patient to take away with them.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed that reception staff greeted patients in a polite and courteous manner. When appointments were made by telephone we overheard receptionists giving patients choices and respected when patients were available to attend on some days. We also noted that dispensary staff were helpful when patients arrived to collect their repeat prescriptions.

A receptionist told us they could ask a patient to speak with them privately in an unoccupied room to protect their confidentiality.

We observed patients being treated with dignity and respect throughout the time we spent at the practice. We saw that clinical staff displayed a positive and friendly attitude towards patients. Patients we spoke with told us they had developed positive relationships with clinical staff who were familiar with their health needs.

Patients confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff. Some people had used the chaperone service and reported to us they felt quite comfortable during the procedure. The practice had a chaperone policy and patients told us they were aware of their right to request a chaperone.

There was a privacy and dignity policy in place and all staff had access to this. We saw that all clinical rooms had window blinds and privacy screening. Clinical staff told us the consulting room door was kept closed when patients were being seen. We observed staff knocking on doors and waiting to be called into the room before entering.

Care planning and involvement in decisions about care and treatment

Patients were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. The patients we spoke with told us they were able to make informed decisions about their care and felt in control.

The Mental Capacity Act 2005 governs decision making on behalf of adults and applies when patients did not have mental capacity to make informed decisions. Where necessary patients had been assessed to determine their ability prior to best interest decisions being made. Staff we spoke with had an awareness of the Mental Capacity Act and had received training.

A nurse practitioner told us they explained tests and treatments to patients before carrying them out and on-going information was provided during the procedures so that patients knew what to expect.

Patient/carer support to cope emotionally with care and treatment

We saw a number of leaflets in the waiting areas for patients to pick up and take away with them. They informed patients of various support groups and their contact details. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Following bereavement the respective GP would contact the family by phone to offer them information about the various bereavement counselling services available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor the service to meet their needs. The practice had a higher than average older population group on their list with 20 percent of patients aged 75+ years and over. We were shown the measures the provider had taken to target patients with diabetes and their regular reviews. The nurse practitioner had attended specialist training in diabetes. .

We found that patients with learning disabilities or mental health conditions were offered an annual health review. Free health checks were available to patients between the ages of 40 and 74. Patients aged 85 and over were also offered annual health checks.

There was an active Patient Participation Group (PPG) which interacted regularly with practice staff through the regular meetings they held. PPGs are an effective way for patients and surgeries to work together to improve services and promote quality care. The meeting minutes told us that both parties kept each other informed about patient's needs.

We observed that senior staff were very accessible to patients and staff and were focussed on improving the service in any way they could.

GPs provided a service to several care and nursing homes. A system of a named GP for each home had been implemented to promote a streamlined system for patients who lived in the homes.

Tackling inequity and promoting equality

We looked at the measures in place to accommodate equality amongst patients and meet and diverse needs. When patients whose first language was not English requested an appointment reception staff automatically gave them a double appointment and arranged for a telephone interpreter service. This enabled effective communication and supported patients to understand their health needs. Patient registration packs included a document written in a total of six languages informing patients to ask for help if necessary in completing their registration application forms.

The automatic entry doors assisted access for patients with restricted mobility. There were accessible toilet facilities and corridors were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor. Senior staff told us about the proposed build of four thousand new homes in the locality and their concerns about their ability to accommodate patients within the current premises. Senior staff informed us of the potential for an additional build of four thousand homes.

Access to the service

Appointments were available weekday mornings and afternoons. Patients could make appointments up to three weeks in advance, for the next day or on the day. There were two early morning a d one late evening facility to make appointments. Reception staff told us children would always be seen on the day an appointment was requested.

Comprehensive information was available to patients about appointments on the practice website, in the practice leaflet and a separate document that provided detailed information about how to access care and urgent attention. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system but two patients we spoke with told us it was getting difficult to obtain appointments. Other comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handled all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to and there were separate leaflets about complaints available at the reception desk.

The practice staff had a system in place for handling concerns and complaints. We were shown a summary of the complaints received during the last 12 months. We saw they had been investigated, responded to and there were

Good

Are services responsive to people's needs?

(for example, to feedback?)

instances where changes had been made to prevent recurrences. Practice staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings. We saw that complaints were discussed during clinical meetings.

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

Senior staff developed a 'practice plan' each year and reviewed progress against the objectives every three months. The 'practice plan' included a mission statement regarding provision of high quality care, respect and courtesy to patients and to keep up to date with developments in health care.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at recordings from meetings held by practice staff that demonstrated the vision and values were still current.

It was evident that senior staff had continued to search for further areas of improvement on an on-going basis. For example, senior staff had developed a positive relationship with the Patient Participation Group (PPG). The members of the PPG we spoke with told us that they had started to communicate with patients and to give feedback to senior staff about patient's opinions about the service they received.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively. There were specific identified lead roles for areas such as prescribing and safeguarding. Responsibilities were shared among GPs, nurses and the practice manager.

We found that the governance arrangements included a local peer review system which focussed on areas for improvement in partnership with neighbouring GP practices.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control; a GP was the lead for safeguarding and another for health and safety. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that practice staff held a range of regular meetings. They included clinical meetings, multidisciplinary meetings for long term conditions, nurse meetings and non-clinical meetings. The practice manager also held monthly meetings with department managers. The minutes told us that all aspects of the running of the practice were discussed as well as ways of taking corrective actions to meet patient's needs.

Practice seeks and acts on feedback from users, public and staff

The practice had an active Patient Participation Group (PPG). The PPG had carried out annual surveys and met every quarter. PPGs act as a representative for patients and work with practice staff in an effective way to improve services and to promote quality care. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The report dated March 2014 included an action log of suggested improvements. For example, patients had stated they did not know enough about the appointments system. The practice staff developed a small booklet which provided details about the system and these were distributed to patients.

We spoke with the chair and vice chair of the PPG. They told us the practice staff worked as a team and the PPG had positive working relationships with staff. They informed us that staff made on-going efforts to improve the quality of the service and constantly searching for ways to improve staff practices. There was a Patient Reference Group (communicated with via email) of approximately 500 members. This was set up to capture opinions from younger patients who may work or be at home with children.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that senior staff were very supportive of training. For example, the trainee nurse practitioner was arranging to attend some study days around infection control to enable them to carry out their lead role in this area effectively.

The practice had completed reviews of significant events and other incidents and shared them with staff via

Are services well-led?

Good

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

meetings to ensure the practice improved outcomes for patients. For example, a letter received at the practice was scanned and entered onto the incorrect patient notes. This was picked up by a GP and further detailed checks were put in place to prevent such a recurrence.

We saw that any serious dispensing errors were treated as significant events and fully investigated. If necessary, improvement actions were taken and the information cascaded to relevant staff.