The Surgery at Nursery Lane and Adel

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Surgery at Nursery Lane and Adel

on 23 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also rated as good for providing services for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, as well as those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from patients, which it acted on.

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information 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?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good 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. 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

Good

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

Patients told us 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)

Good

The practice is rated as good 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

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary 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 had told 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 six patients on the day of our visit. We spoke with people from different age groups, who had different physical needs and had varying levels of contact with the practice. We received 41 completed CQC comment forms. Almost all of these were complimentary about the practice and staff. A small number identified that the telephone booking system was very busy at peak times especially during Monday mornings, which made getting an appointment challenging.

The patients were complimentary about the care provided by the staff and their overall friendliness and behaviour. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and the practice provided a professional and efficient service.

Patients reported they felt all the staff treated them with dignity and respect. Patients told us staff listened to them and were well informed.

Patients said the practice was very supportive and felt their views were valued by staff. They were complimentary about the appointments system, its ease of access and the flexibility it provided.

Patients told us the practice was always clean and tidy.

We reviewed the most recent data available for the practice on patient satisfaction. The evidence from these sources showed patients were satisfied with how they were treated with compassion, dignity and respect. For example, data from the GP patient survey showed 82% of respondents found it easy to get through to this surgery by phone. The local CCG average was 79% and the National CCG average was 73%.

The Surgery at Nursery Lane and Adel

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice nurse).

Background to The Surgery at Nursery Lane and Adel

The Surgery at Nursery Lane and Adel is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the Alwoodley area of Leeds.

A branch surgery 'Adel' also provides the same service in the Adel area of Leeds was also visited as part of this inspection. The two sites had a single patient list, so patients could be seen at either practice depending on what was more convenient for them. The practice had six GP partners (two male and four female), a management team, practice nurses, healthcare assistants and administrative staff.

The practice is open 8:00am to 6:00pm on Monday to Friday with earlier opening times of 7am on Monday and Wednesday. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctor clinics. When the surgery is closed out-of-hours provision is provided by West Yorkshire Urgent Care Services.

The practice has a General Medical Services (GMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

The practice is part of NHS Leeds North Clinical Commissioning Group (CCG). It is responsible for providing primary care services to 8,477 patients. The practice population comprised of an equal number of male and female patients.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

We carried out an announced 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 registered 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 in accordance with the Care Act 2014.

Please note 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 CQC at that time.

Detailed findings

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews. We spoke with GPs, the practice manager, clinical nurses, a midwife, a health care assistant, a cleaner and receptionists.

We observed how staff treated patients when they visited or phoned the practice. We reviewed how the GP made clinical decisions. We reviewed a variety of documents used by the practice to manage the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. For example, recent incidents that were reported and actioned were around diabetic management and bone protection in long term steroid usage.

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 four significant events that had occurred during the last two years and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held bi-monthly to review actions from past significant events and complaints. There was evidence the practice had learned from these and that the findings were shared with relevant staff. 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 team meetings 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 systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, accurately record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Chaperone training had been undertaken by key administration staff, including receptionists. The staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

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 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 were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Patients were routinely informed of common potential side effects at the time of starting a course of medication. The IT

system allowed for 'on screen' messages which were discussed with the patient. Patients were also reassured of side effects; for example for acute courses of steroid creams.

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 prevention and 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 examination couch 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. There was also a policy for needle stick injury and staff we spoke with knew the procedure to follow in the event of an injury.

The practice had a lead for infection prevention and control (IPC) who had undertaken further training to enable them to provide advice on the practice IPC policy and carry out staff training. All staff received induction training about IPC specific to their role and received annual updates. We saw evidence that the lead had carried out audits for the last year and that any improvements identified for action were completed on time.

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

The practice had a risk assessment for the management of legionella (a bacterium found in the environment which can contaminate water systems in buildings). The last assessment had been completed in January 2015; in line with Health and Safety Executive (HSE) guidance.

Equipment

Staff we spoke with told us they had access to 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example blood pressure measuring devices.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and 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.

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

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received

Good

Are services safe?

training in basic life support. Emergency equipment was available including re-stocking of oxygen and an automated external defibrillator, which was used to attempt to restart a person's heart in an emergency. All staff asked knew the location of this equipment and how to use it and records we saw confirmed these were checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with the GP who told us that they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were applied during assessment, diagnosis, and referral to other services, management of long term conditions or chronic conditions. NICE guidance was discussed at monthly clinical meetings.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. Patients who had recently been discharged from hospital were reviewed daily by their named GP according to need.

The practice referred patients appropriately to secondary and other community care services. National data showed the practice was in line with national standards on referral rates for all conditions. All the GPs we interviewed used national standards for the referral of conditions. We saw evidence of appropriate use of referrals for cancer in case notes that we assessed. We saw minutes from meetings where regular review of elective and urgent referrals were made, and that improvements to practise were shared with all clinical staff.

Talking with staff, we were told the culture of the practice was patients were cared for and treated based on need. The practice took into account a patient's age, gender race and culture as appropriate and avoided any discriminatory practises.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 by the practice manager to support the practice to carry out clinical audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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, we saw an audit regarding antibiotic prescribing. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 558 out of a possible 559 points (2014-15) of the total QOF target, which was above the national average.

Clinical audit and staff meetings were used to assess performance. The practice had an effective system in place in order to complete clinical audit cycles. We were provided with summaries of completed clinical audits which had been undertaken in the last 12 months. These related to antibiotic prescribing, amber drug monitoring, bone protection and diabetes. After each initial audit, actions had been identified and changes to treatment or care had been made as appropriate.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. Newly employed staff were supported in the first few months of working in the practice. We were able to review staff training records and we saw that this covered areas such safeguarding, health and safety, fire and first aid. Every GP is appraised annually,

Good

Are services effective?

(for example, treatment is effective)

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.

The practice manager stated all staff received an appraisal yearly. We confirmed this with staff who told us they were able to discuss any issues or training needs with their manager.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately 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 needs. It received blood test results, X-ray results, and letters from hospitals including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP when they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

The practice had recently introduced the 'Leeds Care Record'. Every health and social care organisation holds a different set of records about patients. Information in different records may be duplicated or incomplete. Leeds Care Record is a new confidential computer record containing patient's health and social care information via the GP, hospital, social care or other medical records.

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. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had created a policy to help staff. This was detailed in the consent policy which we looked at. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice had not needed to use restraint in the last five years, but staff were aware of the distinction between lawful and unlawful restraint. Clinical staff we spoke with understood the Gillick competency and Fraser guidelines. These are used to assess whether a child under 16 has the maturity and understanding to make their own decisions and give consent to treatments being proposed.

Health promotion and prevention

The practice offered a full range of immunisations for children, baby clinics held in conjunction with health visitors, travel vaccines and flu vaccinations in line with current national guidance. Last year's (20013-14) performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

The practice was delivering additional services; minor surgery in-house, contraception and implants clinics. Flu vaccinations for pre-school children and pregnant women was also available as well as NHS health checks and dementia screening.

Healthy lifestyle information was available to patients via leaflets and posters in the waiting room and also accessible through the practice website. This included smoking cessation, weight management and travel health. Patients were signposted to other services as the need arose.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice scored 93% for its satisfaction scores on the last GP they saw or spoke to was good at listening to them. The Local (CCG) average was 91% and the national average was 89%.

The NHS friends and family test from January to April 2015 showed the practice's results to be marginally better than for England overall, with 92% of patient responders saying they were likely or extremely likely to recommend the practice after the service they received (compared with 89% for England overall). Also 5% of responders said they were unlikely or extremely unlikely to recommend the practice, compared with 6% for England overall.

Patients completed CQC comment forms to tell us what they thought about the practice. We received 41 completed forms and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident which showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas.

Patients we spoke with on the day of our inspection told us 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 forms we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area.

The patients we spoke with on the day of our inspection and the comment forms 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, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

Good

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 patient's 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.

There had been very little turnover of staff during the last five years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to nursing and residential care homes by a named GP, nurses and health care assistants.

Baby clinics with a GP and the nurse were booked for the same day. This enabled an efficient service to be offered to mothers without the need for three separate appointments. Having mother (post-natal) and child health surveillance checks together, as one appointment, is seen as effective organisation and good consideration of this population group's particular needs. This is considered to be safe practice and also effective for identifying any safeguarding issues.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services e.g. services for asylum seekers, those with a learning disability, travellers, unemployed and carers.

The practice provided equality and diversity training. Staff we spoke with confirmed they had read the 'Equal Opportunities Policy' and that equality and diversity was discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities.

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

Access to the service

The surgery was open from 8:30am to 6pm Monday to Friday. Appointments were available up to 5.20pm on weekdays and early appointments from 7:00am were available on Monday and Wednesday.

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.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed 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 doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often received an appointment for the same day they had contacted the practice.

We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found these were satisfactorily handled.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to 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 the next year's business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice.

The practice identified the building they currently operated from did not have sufficient space for them to undertake all the services they wanted to. They told us they had engaged with patients, the CCG and the local community to support the development of future plans for the practice. The practice was moving to new purpose built premises in the Spring of 2016.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

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 on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

The GPs 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. These included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing better than the average of other practices nationally. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

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.

The practice had robust arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. A system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. The practice used a computerised system to store all documents including any alerts. The staff had also received training in health and safety and infection control. Fire safety procedures and environmental and fire risk assessments were in place and these had been regularly reviewed.

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 GP for safeguarding and a practice nurse was the lead for infection prevention and control.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example dignity and respect policy, confidentiality policy and data protection policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, 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. The PPG had carried out quarterly surveys and met every quarter. 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 three 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).

Are services well-led?

Good

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

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

The practice had a whistle blowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

All GPs were involved in revalidation, appraisal schemes and continuing professional development. They mentored and tutored undergraduate medical students.