Dr Pervez Sadiq

Quality Report

Hillside House Surgery
The Blue Bell Centre,
Blue Bell Lane,
Huyton
Liverpool
Merseyside
L36 7XY
Tel: 0151 489 4539
Website: www.hillsidehousesurgery.nhs.uk

Date of inspection visit: 25 February 2015
Date of publication: 16/04/2015

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

Ratings

Overall rating for this service	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

We carried out an announced comprehensive inspection at Hillside House Surgery on 25 February 2015. Overall the practice is rated as good.

The practice provided safe, effective, responsive care that was well led and addressed the needs of the population it served. The service was caring and compassionate. It was also good for providing services for all the population groups.

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons learnt were disseminated to staff. Infection risks and medicines were managed safely. However, improvements were needed to ensure staff were safely recruited and that required information in respect of staff was held.
- People's needs were assessed and care was planned and delivered in line with current legislation and guidance. Staff had received training appropriate to their roles. Patients experienced outcomes that were in line with or above the national average. The practice used innovative and proactive methods to improve patient outcomes. For example care plans were in place for vulnerable and older patients to reduce unplanned admissions. Recall and review systems for patients with long term conditions were effective.
- Patients spoke highly of the practice. They said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice provided good care to its population that was responsive to their health and socio economic needs. Patients were listened to and feedback was acted upon. Information about services and how to complain was available and easy to understand.

Summary of findings

Complaints were managed appropriately and lesson learnt from them. 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 monitored, evaluated and improved services. There was a clear leadership structure, staff enjoyed working for the practice and felt well supported and valued. The practice proactively sought feedback from staff and patients, which it acted on.

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

.The provider should:

- Ensure its recruitment policy, procedures and arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Child and adult safeguarding was well managed, staff were trained and supported by knowledgeable safeguarding lead members of staff and a deputy. Medicines and infection control risks were managed safely. There were enough staff to keep patients safe. However, improvements were needed to ensure that staff were recruited safely and recruitment arrangements included all necessary employment checks and required information was held on staff.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality, including the Quality and Outcomes Framework (QOF). The practice had achieved good scores for QOF over the last few years (last year they obtained 93.9%. This was above the CCG average and about national average). Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for older, vulnerable patients and those with long term and mental health conditions. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Patients were involved in the development of their care and treatment plans. Staff had received training appropriate to their roles and 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. Results from the National GP Patient Survey, patients we spoke with and those who completed the CQC comment cards were very complimentary and positive about the service and the care and treatment they received. Data from surveys showed that patients rated the practice higher than others for several aspects of care. They said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. We also observed 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. The practice had identified and reviewed the needs of their local population and provided tailored services accordingly. They 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 appointments and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence we reviewed showed that the practice responded appropriately to issues raised with learning and improvements implemented as a result.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and statement of purpose. 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 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. They had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and learning and development events.

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. For example the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average. 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, avoiding unplanned admissions, seasonal flu vaccinations and in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and extended appointments for those with enhanced needs. Patients aged over 75 had a named GP

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place and staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a slightly lower number of patients than the national average number of patients with long standing health conditions (50% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patients with long term conditions effectively. The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected and above the national average. For example, patients with diabetes had regular screening and monitoring and patients with physical and/or mental health conditions had their smoking status recorded.

Nursing staff and GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a

Summary of findings

priority. Longer appointments (for example 20 minute appointments for diabetic reviews) and home visits were available when needed. Patients with long term conditions had an annual review to check that their health and medication needs were being met.

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, the practice maintained a register of children who were subject to a child protection plan. We received positive feedback regarding care and treatment at the practice for this group. Patients we spoke with told us they were confident with the care and treatment provided to them. Appointments were available outside of school hours and the premises were suitable for children and babies. Weekly baby clinics were held with the six week baby review undertaken by the GP at the practice. There was regular support from community health visitors and midwives. Child immunisation rates were around national average for all standard childhood immunisations

The practice responded to the needs of this group well and children or young people were always given a same day appointment or urgent appointment if necessary.

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 to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group such as smoking cessation. The practice offered extended opening hours for patients who worked with a range of early morning and evening appointments.

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 children and adults at risk of abuse, patients with dementia, terminally ill and those with a learning disability. It had carried out annual health checks and offered longer appointments for patients with a learning disability. The practice had a well-developed care plan programme for the most vulnerable 2% of patients and these

Summary of findings

had a named doctor. The practice held a register of all patients in need of palliative care support and they held regular multi-disciplinary meetings where all the patients on the register were discussed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It was able to signpost vulnerable patients and their carers to access for 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). One hundred percent of patients on the mental health register had an agreed documented care plan and 87% of those diagnosed with dementia had received a review of their care in the preceding 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Staff had received training on how to care for patients with mental health needs and dementia and their carers.

Summary of findings

What people who use the service say

We spoke with four patients on the day of our inspection (including one member of the Patient Participation Group). We received 26 completed CQC comment cards. Patients whom we spoke with included older people, those with long term conditions and those with children with learning disabilities.

All patients were positive about the practice, the staff and the service they received. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in July 2014 demonstrated they performed well with 82% of respondents saying they had confidence and trust in the last GP they saw or spoke with. Seventy percent said the last GP they saw or spoke to was good at treating them with care and concern, 99% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Sixty eight percent said they last GP they spoke to or saw was good at listening to them, whilst 68% said the GP was good at explaining treatment and tests. The data demonstrated the practice was performing around average for the majority of questions asked.

We received no concerns regarding the appointment system on the day of inspection from patients we spoke with and the comments cards reviewed. Eighty four percent of patients responding to the National GP Patient Survey said it was easy to get through to the surgery by phone. Seventy three percent described their experience of making an appointment as good, with 87% saying the last appointment they got was convenient. Only 31% of respondents with a preferred GP got to see or speak to that GP. This was confirmed by patients we spoke with and all patients told us they were able to get an appointment or speak to a GP on the same day in the case of urgent need.

Patients told us they considered that the environment was clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- The provider should ensure its recruitment policy, procedures and arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.

Dr Pervez Sadiq

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP and a specialist advisor who was a Practice Manager.

Background to Dr Pervez Sadiq

Dr Pervez Sadiq, Hillside House Surgery is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 3100 patients living in the Huyton area of Merseyside. The practice has two male GPs, a practice manager, practice nurse, healthcare assistant, administration and reception staff. Dr Pervez Sadiq holds a General Medical Services (GMS) contract with NHS England.

The practice is open Monday to Friday from 9.00am to 5.30pm with an extended surgery on Wednesday until 8.00pm. Patients can book appointments in person or via the telephone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Knowsley Clinical Commissioning Group (CCG). The practice is situated in an area with high deprivation. The practice population is made up of a slightly higher than national average patients aged under 18 and a lower than national average of patients aged over 65 years. Fifty percent of the patient population has a long standing health condition, whilst 44% have health related problems in daily life. There is a higher than national average number of unemployed.

The practice does not deliver out-of-hours services. Out of hours services are provided by UC24. This service is commissioned by Knowsley PCT.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band 6 representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

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

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

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

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

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 practice's 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 face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GPs, practice nurse, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. 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. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development. We looked at some recent significant events from 2014 which had been analysed, reported and discussed with relevant staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice manager, GPs and any other relevant or involved staff reported and investigated the significant events. Documented evidence confirmed that incidents were appropriately reported. Action was taken to learn lessons and put measures in place to reduce the risk of the event recurring. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

Learning and improvement from safety incidents

There were records of significant events that had occurred during the previous 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda. The minutes of practice meetings we reviewed showed that complaints, incidents and significant events, were discussed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including GPs, receptionists, administration and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The practice told us they did not carry out an overview of significant events every six to 12 months in order to identify themes or trends; however they were considering implementing a system to do this.

Staff used incident forms that they sent to the practice manager. They showed us the system used to manage and monitor incidents. We tracked some of these incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example in the case of a sudden death due to heart disease, the practice had fully investigated and learnt from this. Practice procedures had been improved with NHS Health Checks for patients aged 40 – 70 years old implemented to help ensure at risk patients were identified and monitored where possible. This was being rolled out to the 20% eligible patients on their patient list. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice manager and learning disseminated to the whole team when relevant. GPs told us significant events were included in their appraisals in order to reflect on their practice and identify any training or policy changes required for them and the practice.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. For example the recent guidance on Ebola (Ebola is a contagious viral infection causing severe symptoms and is currently causing an epidemic in West Africa). They also told us relevant 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. The practice had up to date safeguarding child and adults, policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected

abuse and at risk patients. The policies were easily available to staff on their computers and linked to the local authority's safeguarding policies and procedures for guidance. Staff had access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in clinical and administrative areas.

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Clinical staff had a higher level of training than other staff (Level three). All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were made aware through an alert system on the computer and electronic records of vulnerable people and their immediate families. They were also aware of their responsibilities and knew how to share information, properly record and document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for guidance and advice were accessible.

The practice had a dedicated GP as lead in safeguarding and the practice manager acted as the deputy. They had attended appropriate training to support them in carrying out their work, as recommended by their professional registration safeguarding guidance. All staff we spoke to were aware of the leads and who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The clinical and non-clinical staff were fully aware of the vulnerable children and adult patients at the practice and discussed them at regular clinical meetings

The practice had a current chaperone policy. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told that only staff who had undertaken appropriate training acted as a chaperone; we saw that some reception/administrative staff who had undertaken chaperone training and were able to undertake these duties were checked through the Disclosure and Barring Service (DBS). (These checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines that we checked were found to be in date.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing within the practice had been identified as being above average. Audits had been undertaken and improvements noted were evident.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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. Medicines for use in medical emergencies were kept securely in the treatment rooms. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. There was

oxygen available for the practice to use in case of an emergency. This was checked for function regularly and checks recorded. The practice also had emergency medicine kits for anaphylaxis and first aid. There was a system in place for monitoring and checking of medicines carried in GP bags. This was done by the individual GPs. We found that the range of medicines held in the GP bag we looked at was extensive, well organised and were in date.

The practice staff and GPs were supported by the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends. The CCG medicines management team visited the practice and regular meetings were held with them.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurses and the health care assistant had received appropriate training to administer vaccines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place however cleaning was carried out by an external provider under contract and we found incomplete cleaning schedules and monitoring for the premises. The practice did not monitor the cleaning standards themselves. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There were processes in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities, couches were washable and clean and curtains were labelled with the date they were changed and renewed. This was six months ago. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves were available in the treatment/consulting rooms.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Procedures for the safe storage and disposal of needles and clinical waste products were evident in order to protect the staff and patients from harm.

The practice had a lead for infection control (this was the practice manager who was also a practice nurse) who had undertaken further training to enable them to provide advice on the practice infection control policy. Infection control training was undertaken by all staff and they and received annual updates. Appropriate level of training and updates was evident for different roles (clinical and non-clinical). Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling specimens.

The practice had an infection control audit undertaken by the community infection control team in December 2014. We saw the outcome report with actions implemented. Minutes of practice meetings showed that the findings of the audits were discussed. The practice scored 98% at the last audit.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw evidence of this displayed in all clinical and treatment rooms.

We found that the practice had regular checks carried out for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). This was carried out by the premises management company.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. There were contracts in place for annual checks of fire extinguishers and portable appliance testing (PAT). All portable electrical equipment and fire fighting equipment was routinely tested and displayed stickers indicating up to date testing. Most of the premises equipment and utilities were maintained and checked by the premises management company. We saw that annual calibration and servicing of medical equipment was up to date also, for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Good

Are services safe?

Emergency drugs were stored in a separate cupboard. There was an appropriate range of emergency drugs available, however these were kept loose and may not be easy to retrieve all at once in an emergency. The practice emergency equipment included nebulisers. There was an oxygen cylinder and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) available for use by the practice.

Staffing and recruitment

There was an up to date recruitment policy in place. However this was not in line with current guidance and regulations and did not contain sufficient information to ensure a suitable process was in place for safe recruitment of staff.

We looked at four staff files including clinical and non clinical staff. We found that not all the required information relating to workers was available. We found evidence that a Disclosure and Barring Service (DBS) check had been undertaken for all staff (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). However we did not find evidence of other required information relating to workers. For example we saw that one reference had been followed up for the two most recently employed staff. For all other staff there was no evidence of references, qualifications, photographic identification, medical references or interview records.

There was no system in place to ensure clinical staff's professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) were monitored and checked regularly. We discussed this with the practice manager who told us they would implement a system to ensure these checks are maintained. On the day of inspection we saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

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 annual and monthly checks of the building, the environment, medicines management, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative for the practice. Environmental risk assessments were undertaken by the premises management in conjunction with the practice. The practice also undertook their own fire risk assessments.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely on site.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: ill children and young people were always given an appointment the same day and within a short time scale where assessed as needing to be seen urgently.

Arrangements to deal with emergencies and major incidents

A current business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. 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. Staff we spoke with were aware of the business continuity plan and could describe what to do in the event of a disaster or serious event occurring for example in the event of an IT failure.

The practice had arrangements in place to manage emergencies. Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. Records showed that all staff had received training in basic life support and this was updated annually. There was emergency equipment and medicines

Good

Are services safe?

available including access to oxygen and an automated external defibrillator. Staff knew the location of this equipment and records confirmed that it was checked regularly. However these items were held on another floor of the building by another provider. There was access to the equipment but it was shared between four practices and another provider. This may be a risk due to the number of patients it served. These were maintained and checked regularly. Drills to test out the accessibility of emergency equipment were undertaken. This had initially identified an issue with access to the equipment in the absence of a receptionist; however this had since been rectified with the practice now holding their own access card to the equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The building was owned by NHS Estates who contracted a company to manage the premises. A fire risk assessment had been undertaken that included actions required maintaining fire safety. Records showed that firefighting equipment and fire safety equipment (such as fire alarm) were routinely checked and maintained under contract.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and used current best practice. The staff we spoke with and evidence we reviewed confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care plans of patients' needs and these were reviewed appropriately. NICE guidance was stored on the shared drive in the computer system so that staff had easy access to them. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

GPs and practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. GPs also specialised and led in clinical areas such as safeguarding and various chronic diseases. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. Multi-disciplinary team meetings also demonstrated sharing and evaluation of care and treatment for older people, those with long term conditions and those in need of palliative care support with external health and social care workers.

Older patients and those with long term conditions and mental health needs including dementia were well cared for by the practice. All vulnerable older patients and patients at risk of unplanned admission to hospital had comprehensive care plans in place which were reviewed. Care plans were developed in conjunction with the patient and they were involved in decisions regarding their care and treatment. This was confirmed by patients we spoke with. For example we saw that 100% of patients who were registered as having a learning disability and 100% of patients registered as having mental health problems had had an annual health check done and an action plan agreed.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw audits and monitoring of urgent cancer referrals took place to ensure patients received the appropriate care they needed. We saw that the practice's referral rates for healthcare conditions reflected the national standards for referral rates. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP. In the absence of the named GP for the patient the duty doctor would assess and action any such information.

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 the basis of need and that age, sex and race was not taken into account in this decision-making.

We spoke to clinical staff who demonstrated knowledge and understanding of obtaining consent. There were no minor surgical procedures which would require written consent to be undertaken in the practice.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved a score for QOF of 93.9% last year which demonstrated they provided good effective care to patients. QOF information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average. QOF information also indicated that patients with long term health conditions received care and treatment as expected and above the national

Good

Are services effective?

(for example, treatment is effective)

average including for example patients with diabetes had regular screening and monitoring, clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations.

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 was used to inform and support clinical audits. The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients who were vulnerable and for those with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). These registers were used to identify and monitor patients' health needs and to arrange annual health reviews.

The practice had a system in place for completing clinical audit cycles and maintained an annual audit program. Examples of clinical audits included antibiotic prescribing, the use of antipsychotic medication and increased incidence of falls in people with dementia, assessment of dermatology referrals, chaperone use, cancer diagnosis and referrals and inadequate smear rate. We looked at some of these audits that the practice had undertaken. Some of these were fully completed audits where the practice was able to demonstrate the changes resulting since the initial audit and some were ongoing audits. We were given examples of where audits had improved patient outcomes and ensured the practice worked within NICE guidelines, for example in patients with dementia there was a reduction in use of antipsychotic medication.

Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision, locality performance indicators and QOF. For example, we saw an audit regarding the emergency drugs held in the practice. Following the audit, the practice obtained supplies of a range of relevant emergency drugs and ensured systems were in place to monitor their condition and expiry dates. We saw data from the local CCG that demonstrated the practice's performance for antibiotic prescribing, which was slightly higher than other practices. The practice had completed an audit of antibiotic prescribing and had implemented changes in practice as a result.

GPs maintained records showing how they had evaluated the service and documented the success of any changes. Discussion of audits, performance indicators and quality initiatives was evident in meeting minutes. Staff told us they received feedback at meetings.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. Evidence confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Patients we spoke with also told us they were well cared for and had medicine and long term condition reviews regularly. They were sent for and reminded by the practice to attend for their reviews.

The practice implemented the Gold Standards Framework for end of life care. One of the GPs took the lead for this group of patients supported by the practice nurse and administration staff. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The patient's care plan and any other relevant information were shared with the out of hour's services to inform them of any particular needs of patients who were nearing the end of their lives.

Effective staffing

There was an induction check list in place which identified the essential knowledge and skills needed for new employees. We spoke to a new member of staff who confirmed that they had received an induction this was basic in detail and documented.

Good

Are services effective?

(for example, treatment is effective)

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that generally staff were up to date with attending mandatory courses such as annual basic life support, fire safety, infection control and safeguarding.

The practice manager kept a record of training carried out by all staff. We noted that the system was not easy to follow and did not enable training needs to be identified easily to ensure good oversight and management of training and development. The practice manager told us that they would develop a system to enable them to maintain more detailed information about all training undertaken that would help them to plan for future training needs

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice supported training and development and provided funding for relevant courses. Both GPs were up to date with their yearly continuing professional development requirements and they both had recently been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The GPs were supported by the practice nurses in lead roles such as leads for diabetes and heart disease. The practice nurses and GPs had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Additional role specific training had been undertaken by clinical staff to support them in these roles.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology Those with extended roles e.g. seeing patients with long-term conditions such as COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex needs. We were shown how the practice provided the 'out of hour's' service with information, to support, for example, end of life care. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post and we saw that this information was read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

The practice worked closely with other health and social care providers in the local area. They told us how they worked with the community mental health team, social workers, midwives and health visitors to support patients and promote their welfare. The practice held multidisciplinary team meetings (monthly) to discuss the needs of complex patients, for example those with end of life care needs. The clinical staff worked and communicated closely with specialist services that visited and held clinics in the health centre. GPs would regularly have meetings and discussion with these clinicians regarding individual patients.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. 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 appropriately. The practice undertook audits of the correct workflow of hospital discharge letters which demonstrated the practice were caring for their patients appropriately. The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings. We saw a variety of documented meetings between the practice and these staff which confirmed good working relationships between them and good review and joint decision making in patient care.

Good

Are services effective?

(for example, treatment is effective)

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 patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Electronic systems were also in place for making referrals, and the practice made the majority of its referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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. They provided us with examples which demonstrated their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). The practice had policies and procedures to support staff around consent, including guidance on "do not attempt resuscitation". Patients we spoke to confirmed that decisions involving patients who lacked capacity were made appropriately..

The practice did not undertake minor surgical procedures interventions that require formal written consent. Implied consent was obtained for child immunisations with documentation of explanation and consent obtained in the records.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example records showed 100% of patients who were on the learning disability register had care plans in place and these had been reviewed in last year). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and posters in the waiting area about the services available. This included smoking cessation, obesity management and travel advice.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice also offered NHS Health Checks to all its patients aged over 40. There was a named GP for patients aged over 75.The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for children's immunisations was around average nationally. Seasonal flu immunisation rates for the over 65 group were also above average for the CCG. There was a clear policy for following up non-attenders by the practice nurse.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

The practice's performance for cervical smear uptake was 76% last year, which was around average. There was a

Good

Are services effective?

(for example, treatment is effective)

policy to remind patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area so as to avoid being overheard.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

We looked at 26 CQC comment cards that patients had completed prior to the inspection and spoke with four patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring and helpful. Patients we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey 2014 found that 70% of patients at the practice stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern. Ninety nine percent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. Seventy nine percent of patients who responded to this survey described the overall experience of their GP surgery as fairly good or very good.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms.

There was a clearly visible notice in the patient reception area and on the website stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients who we spoke with and who made comments via the CQC comments cards, told us they felt involved in decisions about their own treatment, they received full explanations about diagnosis and treatments and staff listened to them and gave them time to think about decisions.

The patient survey information we reviewed generally showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the National GP Patient Survey 2014 demonstrated 61% of patients said the GPs were good at involving them in decisions about their care and 94% felt the nurses were good or very good at involving them in decisions about their care. These results for feedback regarding nurses care was above average compared to nationally, however feedback regarding GPs care and treatment was in some aspects slightly lower than national average. The practice had reviewed these findings and was trialling an appointment system to give patients 15 minute appointments as opposed to the usual ten minutes. It was hoped this would give GPs more time to listen to and involve the patient to improve the patient experience.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, 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.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Patients told us they had enough time to discuss things fully with the GP, they felt listened to and felt clinicians

Good

Are services caring?

were empathetic and compassionate. Results from the National GP Patient Survey told us that 76% of patients said the last GP they saw or spoke to was good at giving them enough time, 68% said the GP was good at listening to them and 68% said they were good at explaining tests and treatment.

The practice implemented the Gold Standards Framework for end of life care. They had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We saw evidence of these meetings minutes. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice nurse were able to refer patients on to counselling services. Patients we spoke with who suffered bereavement had confirmed they had received support from the practice and said they found it compassionate and caring.

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. The practice signposted carers to support led by community services and were able to refer directly to bereavement services. One of the receptionists was identified as the carers lead. They had undertaken further training to support them in their role and had been proactive in identifying carers and supporting them with access to specialised services.

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 patients' needs and had systems in place to improve and maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions, learning disabilities and mental health conditions.

The practice was responsive to the needs of older patients, those with long term conditions and mental health conditions and vulnerable patients. They offered home visits and extended appointments for those with enhanced needs. This was to ensure patients had appointments that meet their needs for care and health reviews. Patients received their relevant annual health checks and had care plans in place that were reviewed regularly.

The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

The practice had an active Patient Participation Group (PPG). We spoke with one member of the group and looked at their agendas and meeting minutes. Practice staff attended the PPG meetings on a regular basis where good information exchange took place. The PPG told us the practice listened to them and they were able to contribute views and suggestions that, if appropriate, were acted upon.

The practice reviewed patient feedback from a number of methods including the last National Patient GP Survey (2014), comments cards, and Friends and Family test and identified some areas where satisfaction with the service had fallen. We saw and were told about an action plan to address the key issues. For example, the practice had implemented a trial of 15 minute appointment slots instead of the usual ten minutes to try to improve satisfaction with waiting times and GPs listening to and involving patients.

Tackling inequity and promoting equality

The medical centre building in which the practice was housed was purpose built and provided good access to disabled people. There was a large car park with dedicated disabled spaces. The reception and waiting areas were large and spacious. There were disabled toilet facilities, baby changing facilities, a lift and induction hearing loop.

The practice analysed its activity and monitored patient population groups including those living in vulnerable circumstances. This enabled them to direct appropriate support and information to the different groups of patients. They held a register of people who may be living in vulnerable circumstances and had a system for flagging vulnerability in individual records. Patients were able to register with the practice, including those with "no fixed abode" care of the practice's address and we were told they would not been turned away just because they were not registered or were homeless.

The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services. They had tailored services and support around the populations needs and provided a good service to all patient population groups. However the practice did not routinely provide equality and diversity training for all staff.

Access to the service

The practice was open Monday to Friday 9.00am until 5.30pm with extended opening hours once a week until 8.00pm. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advise and appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider. The practice offered pre bookable and urgent (on the day) appointments and home visits. Appointments could be made in person, by phone or by the automated telephone system. Priority was given to children; babies and vulnerable patients identified as at risk due to their condition and these patients were always offered a same day or urgent appointment. The practice's extended opening hours on Wednesday was particularly

Good

Are services responsive to people's needs?

(for example, to feedback?)

useful to patients with work commitments and those with children of school age. The practice understood the needs of their local population. It had a higher than average number of unemployed who did not need to take up early morning appointments. The practice stayed open during the lunchtime to accommodate their patients' preferences.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to care homes, older patients and those vulnerable housebound patients.

Patients we spoke with, comment cards and patient survey results told us patients were satisfied with the appointment system. They told us there was usually no difficulty getting through to the practice on the telephone or getting an appointment. The practice performed well in patient surveys for access to the appointments system with 77% satisfied with the practice's opening hours, 84% saying they found it easy to through to the practice by phone and 73% described their experience of making an appointment as good. Overall satisfaction with the practice (at the last patient survey) was good; 79% of patients described their overall experience of the practice as good, which was around the national average.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance. The practice manager and partner GP managed the complaints and they liaised with all relevant staff in dealing with the complaints on an individual basis. A summary and overview log was not in place which would have enabled analysis of the complaints into subjects and themes. Complaints were not reviewed overall on an annual or more frequent basis. Complaints were discussed individually and regularly at meetings to disseminate learning and improvements in practice.

We looked at the complaints log for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. We examined complaints and found that full investigation and good reporting had taken place. We noted in one particular case that there was good communication with detailed clinical explanation to the complainants and efforts had been made to support the complainants in meeting with other healthcare professionals and services.

We saw that information was available to help patients understand the complaints system. Information was seen in reception, on the website and in the complaints leaflet. Patients we spoke with were aware of the complaints procedure, although none had needed to use it. An appropriate information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. We noted this gave information regarding other contacts to which a patient could raise concerns such as the local NHS England team and the Care Quality Commission. Staff we spoke with were able to tell us how they would handle initial complaints made at reception or by telephone.

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 give patients an excellent service and provide high quality holistic care. We did not see that the vision or a mission statement was displayed for staff and patients to see. The practice had a statement of purpose that highlighted patients were the focus of the practice.

Staff were able to articulate the vision and values of the practice. Staff understood what their responsibilities were in relation to these. Staff were proud to work for the practice and had good relationships with neighbouring practices and health and social care colleagues.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy in the offices. Generally policies and procedures were dated and reviewed appropriately and were up to date. Some for example the recruitment policy needed review to ensure that it met the requirements relating to safe recruitment of staff. Staff confirmed they had read them and were aware of how to access them.

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control; GP lead for safeguarding, palliative care, learning disability and mental health. We spoke with staff in different roles and they were all clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above the CCG average and around national average. For 2013/14 the practice obtained 93.9%. We saw that QOF data was regularly monitored and discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Clinical audits were undertaken regularly by nursing and medical staff. We looked at a selection of these. Generally they were completed well; with review of actions and improvements evident.

The practice held regular practice, multi-disciplinary and clinical meetings that were documented. We looked at sample minutes from these and found that performance, quality, significant events and complaints had been discussed.

Leadership, openness and transparency

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example being open, bullying and harassment, recruitment and selection policies which were in place to support staff. Some of the human resources procedures needed review to ensure that they met requirements for safely recruiting staff. Recruitment and induction procedures needed to reflect policy and ensure that when staff are recruited and inducted full information in respect of these is documented.

Staff felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. All the staff we spoke with told us they felt they were valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately. The leadership of the practice was caring, enthusiastic and motivated about the service they provided and about caring for their staff.

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

The practice had gathered feedback from patients through patient surveys, comments cards, complaints and the Friends and Family test (FFT) The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. We looked at the results of the annual patient survey and we looked at the practice's action plan in response. Actions had been taken in response to areas for improvement. We looked at complaints and found they were dealt with appropriately.

There was an active Patient Participation Group (PPG) which had a good relationship with the practice. They felt

Are services well-led?

Good

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

listened to and valued with the practice acting on suggestions put forward by the PPG where appropriate. The group met quarterly and members of the practice also attended. Information was seen in the waiting room to try and promote uptake of membership of the group.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff told us they had no concerns about reporting any issues internally. The practice also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Regular monthly meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

Management lead through learning and improvement

We saw that all staff were up to date with annual appraisals which included looking at their performance and development needs. Staff told us appraisals were useful and a good two way process. The practice had a basic induction programme. Staff undertook training relevant to their role. Staff told us they had good access to training and were well supported to undertake further development in relation to their role.

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