Deben Road Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	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 Deben Road Surgery on 24 March 2015. Overall the practice is rated as good.

The overall rating for this practice is good. We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

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

- The practice was a, friendly, caring and responsive practice that addressed patients' needs and that worked in partnership with other health and social care services to deliver individualised care.
- The clinical and administrative team had a good understanding of the needs of their patient population. This was particularly the case in relation to those patients who were at most risk of poor health whose care was proactively managed through personalised care plans.
- Staff were multi-skilled and could carry out a variety of roles.
- 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.
- Patients' needs were assessed and care was planned and delivered following best practice. guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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 and easy to understand.

Summary of findings

- Patients said they found it easy to make an appointment 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 needs.

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

Importantly the provider must;

- Ensure that safe and clinically supervised systems are in place for the review of all patient correspondence.

Importantly the provider should;

- Ensure there are systems in place to monitor and assess health and safety risks on an on-going basis.
- Prescription stationery was securely stored and some record keeping was in place, but there was scope to ensure that the audit trail was complete
- Sustain its efforts to set up and maintain an active PPG so that patients are able to formally contribute to the development of the practice.
- Ensure staff are able to see clearly see patients in the waiting area in the event of any sudden deterioration in a patient's health or wellbeing
- Ensure all staff are familiar with the practice business continuity plan and are familiar with whistleblowing procedures.
- Ensure there is a systematic programme of clinical audit and that action is taken when

improvements are identified.

- Ensure that all staff who chaperone are confident in their understanding of the role.
- Review and strengthen the arrangements for staff meetings.
- Ensure there is a culture of consultation and challenge in which all staff can contribute to the direction of the practice.

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? The practice is safe and is rated as good. The practice was consistent over time in its approach to dealing with safety incidents. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed except that medicine safety alerts were not always responded to effectively. Risks to patients were assessed and properly managed, however the practice had not undertaken a health and safety risk assessment. There were enough staff to keep people safe. The practice had plans in place to respond to events that might interrupt their service.	Good
Are services effective? The practice is effective and is rated as good. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing their mental capacity and promoting good health. However we were told that not all GPs reviewed normal pathology test results or treatment records for patients who had used the out of hours/111 service. Staff had received training appropriate to their roles and any further training needs had been identified and planned. However not all staff felt their chaperone training was adequate or fully understood their role as a chaperone. All staff received appraisals of their performance and had personal development plans in place to ensure their practice was kept up to date Staff worked with multidisciplinary teams for patients receiving end-of-life care. The practice ran a range of clinics to promote health and prevent ill-health. The practice was proactive at identifying patients who cared for others.	Good
Are services caring? The practice is caring and is rated as good. Survey data showed patients rated the practice as good and satisfaction rates were average. This was in-line with patients' views expressed during inspection and through comment cards where experiences were reported as positive. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand	Good

Summary of findings

the care available to them. Staff treated patients with kindness and respect ensuring confidentiality was maintained although conversations sometimes took place in earshot of other patients. There was a chaperone service in place. Patients were supported emotionally in relation to their care and treatment, particularly those who were receiving end of life care or those who were recently bereaved.	
Are services responsive to people's needs? The practice is responsive to people's needs and is rated as good. The practice reviewed and understood the needs of their patient population particularly those who were at risk of unplanned hospital admissions. The practice ran a proactive care register for those who were most at risk and provided personalised care plans for this group of patients. Patients reported good access to the practice with urgent appointments available the same day as well as late appointments each week. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.	**Good**
Are services well-led? The practice is rated as good for being well-led. The practice had a vision and a strategy to deliver this and all staff were aware of their roles and responsibilities in relation to it. There was a leadership structure documented and most staff felt supported by the GPs and management. The practice had a number of policies and procedures to govern activity and these were reviewed in order to reflect best practice. Issues were addressed immediately and revisited during formal meetings, although these were infrequent. The practice was receptive to patient feedback and aware of the patient group needs and in the process of formalising arrangements to capture views. All staff had received inductions, regular performance reviews and attended staff meetings and events.	**Good**

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 The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people such as dementia and chronic lung conditions. The practice took steps to actively identify patients who cared for others in order to facilitate access to other services. Patients aged 75 and over had their own allocated GP but could choose to see another GP if they wished. Flu vaccines for older people who had problems getting to the practice were administered in the community by the attached district nursing team. GPs and the practice nurse undertook home visits for patients who were unable to get to the practice. The practice appropriately coordinated a multi-disciplinary team for the planning and delivery of palliative care for people approaching the end of life. The practice website included a number of links containing extensive information about the promotion of health for a number of different population groups including older people. The practice maintained a proactive care programme for those patients who were most at risk and who had their own, personalised care plan.	**Good**
People with long term conditions 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 as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.	**Good**
Families, children and young people 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 A&E attendances. Immunisation rates were relatively high for all	**Good**

Summary of findings

standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and social workers.	
Working age people (including those recently retired and students) 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. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care such as telephone consultations by appointment. For example following concerns raised by patients who worked full time, the practice had introduced extended hours appointments twice a week. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group, including health checks for patients over 40.	Good
People whose circumstances may make them vulnerable The practice is rated as good for the population group of people whose circumstances might make them vulnerable. Home visits and telephone consultations were available for people who could not get to the surgery. There was also access for people with restricted mobility. People with a learning disability were identified on a register and their care, including their physical health, was proactively managed. This incorporated an annual health check. The practice had a vulnerable adult safeguarding protocol in place and followed guidance set out under the Mental Capacity Act 2005 to assess the capacity of certain patients to consent to care and treatment where that capacity was in doubt. The practice accepted patients on a temporary residence basis if this was required and any person whose treatment was regarded as immediately necessary.	Good
People experiencing poor mental health (including people with dementia) The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).	Good

Summary of findings

There were triggered, opportunistic health screening for patients with dementia who were recognised by the computer system to have contributory comorbidities such as diabetes or lung conditions. Patients with dementia were also reviewed at least annually for a check on their physical health as well as for a review of their mental health needs and to ensure that they were properly engaged with the community mental health services. The care of people with dementia was managed through the proactive care arrangements.

The practice referred patients to an independent well-being counselling service that ran counselling sessions at the practice when required. There were good links to local mental health services.

One GP at the practice had a specific interest in mental health issues and GPs recognised that some patients with mental health needs expressed a strong preference for their usual doctor. As a result to the practice made arrangements to facilitate this need by accommodating double appointments during quieter periods at the surgery wherever possible.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of our inspection. Everyone we spoke with reported that they were treated with kindness, respect and dignity by all the staff at the practice and that they were provided with plenty of information about their care and treatment. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. They also reported that they could easily get an appointment and that the practice was responsive to their needs.

We collected 11 comment cards that had been left for us by patients in advance of our visit. Only wholly positive experiences of patients were reported on the comment cards with none of the cards indicating any negative or critical views, however one card commented that it could sometimes be difficult to make an appointment with a specific GP. Some of the cards referred to GPs and staff by name, singling out individual examples of kindness, care and compassion.

We reviewed data from the most recent national patient survey. We noted that 90% of patients responding to the survey stated the last appointment with the practice was convenient with 83% stating that they felt the practice was good or very good; these were among the middle range of ratings nationally. The survey also showed that patients felt the GP and the nurses were good at giving them enough time, good at listening to them and good at explaining test results to them and good at involving them in decisions about their care. These satisfaction rates were similar to the average for both the local Clinical Commissioning Group (CCG) area and for England in general as were the satisfaction rates about patients experience of making an appointment. Generally the survey indicated a positive experience of patients with satisfaction rates in-line with the national average for opening hours and appointment availability.

Areas for improvement

Action the service MUST take to improve

- Ensure that safe and clinically supervised systems are in place for the review of all patient correspondence.

Action the service SHOULD take to improve

- Ensure there are systems in place to monitor and assess health and safety risks on an on-going basis.
- Prescription stationery was securely stored and some record keeping was in place, but there was scope to ensure that the audit trail was complete
- Sustain its efforts to set up and maintain an active PPG so that patients are able to formally contribute to the development of the practice.
- Ensure staff are able to see clearly see patients in the waiting area in the event of any sudden deterioration in a patient's health or wellbeing
- Ensure all staff are familiar with the practice business continuity plan and are familiar with whistleblowing procedures.
- Ensure there is a systematic programme of clinical audit and that action is taken when improvements are identified.
- Ensure that all staff who chaperone are confident in their understanding of the role.
- Review and strengthen the arrangements for staff meetings.
- Ensure there is a culture of consultation and challenge in which all staff can contribute to the direction of the practice.

Deben Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by another CQC inspector, a GP specialist adviser and a practice manager specialist adviser.

Background to Deben Road Surgery

The practice provides primary medical services to approximately 7,827 patients who live in a densely populated area in the town of Ipswich. According to Public Health England, the patient population is predominantly White English. The premises are purpose built with limited room for growth. Parking is restricted to local streets.

The practice has a team of four GPs meeting patients' needs. All four GPs are partners meaning they hold managerial and financial responsibility for the practice.

There are four practice nurses, three of whom are advanced practitioners and who run a variety of appointments for long term conditions and family health. There is also a healthcare assistant. A health visitor is attached to the practice and a community midwife runs occasional sessions there.

There is a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.30am and 6.30pm, Monday to Friday with additional hours from 7am Tuesday mornings and between 6:30pm and 7:30pm Thursday evenings. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was 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.

This provider had not been inspected before and that was why we included them in this round of inspections.

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. During our inspection we spoke with a range of staff including GP partners, practice nurses, the health care assistant, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff were able to give examples of dealing with concerns and were aware of the process they should use to report safety concerns and the named staff member with responsibility for various areas at the practice such as health and safety and infection control.

There were systems for dealing with alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These alerts were issued to help reduce risks to patients who receive NHS care and to improve safety.

Records held of significant events and complaints showed that issues had been considered in a timely way. 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 over time and so could show evidence of a safe track record. Safety processes were in place for the checking of electrical equipment and fire safety equipment.

The practice held daily mid-morning meetings with all clinicians, however these were not minuted. We were told and we saw from other meeting minutes that significant events and safety incidents were discussed between the GPs, advanced nurse practitioners, practice nurses and the practice. Where any action was required to ensure patients were safe then this was taken quickly and robustly.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw a significant event policy and documentation which facilitated the process of significant event reporting, investigation and promoted review at regular intervals. We saw evidence that learning had taken place from an incident where medicine was prescribed to a patient, but the appropriate monitoring had not been put in place. We saw evidence that the case was discussed in a practice meeting and with individual GPs for learning across all clinical staff members. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and told us they felt encouraged to do so.

We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result such as changes to GP referral processes. 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.

Staff including receptionists, administrators and nursing staff told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

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 that staff had received relevant role specific training on safeguarding. 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.

There was a GPs lead in safeguarding vulnerable adults and children and they could demonstrate they had the necessary training to enable them to fulfil this role. 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. 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 and patients with co-morbidities/multiple medications who required repeat medication reviews.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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). The nursing staff, including health care assistants, had been trained to be a chaperone. We were told that other staff required to act as a chaperone if nursing staff were not available had undertaken chaperone training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. However, some staff we spoke with told us they were not aware of the training and did not fully understand the role of a chaperone. We spoke with one clinician with an interest in family planning and sexual health. They described the robust induction procedure they used with the non-clinical members of staff they had asked to act as a chaperone. They told us this ensured the member of staff fully understood their role as a chaperone. We discussed the concerns raised by staff regarding chaperone training with the GPs and practice manager, it was agreed the practice would formalise in-house chaperone training for all non-clinical members of staff with this clinician.

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

Medicines management

We spoke with a practice nurses and the practice manager and checked medicines stored in the treatment rooms and refrigerators. Medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that temperature sensitive medicines, such as childhood, flu or travel vaccines, were kept at the required temperatures. Refrigerator temperatures were monitored daily using the minimum, maximum and actual measurements allowing the staff to be assured that they remained safe to use. Vaccines were rotated in the refrigerator so that they were used in date order.

Medicine stocks were monitored by the practice nurses who ensured that the practice was adequately stocked with the appropriate medicines. For example, the emergency medicines were kept in a box, we looked at the log to show that these were regularly checked to ensure the medicines remained 'in date' and safe to use. The practice did not stock any medicines categorised as controlled drugs.

The practice nurses 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 had received appropriate training to administer vaccines. Two of the nursing team were also qualified to review and to prescribe medicines.

There was a safe system in place for managing repeat prescriptions. Prescriptions could be ordered by hand, by post, through the local pharmacy or by using the practice's online system and we saw that there was a safe system in place for receiving, checking, authorising and re-issuing prescriptions. Prescription stationery was stored securely and there was some record keeping, however the practice were not able to account for the removal of individual prescriptions from the stock.

Cleanliness and infection control

The practice had a lead for infection control who had received appropriate training. Staff had received hand washing guidance so they understood the appropriate technique to reduce the risk of infection. We were told infection control training was being organised for staff if relevant to their role. An infection control audit was taking place annually and this had been completed to a satisfactory standard. Where areas for improvement had been identified these had been actioned in a timely manner.

We saw that cleaning schedules were in place and cleaning records were kept. A schedule was in place that identified the type of cleaning to be undertaken, the frequency and the materials and equipment to be used. This included colour coded mops to reduce the risk of cross contamination. The quality of the cleaning was monitored by the practice manager and infection control lead.

We observed the premises to be clean and tidy. This included the consultation and treatment rooms, the reception and waiting area and the toilet facilities. There were adequate supplies of paper towels and liquid soaps for the use of patients and staff. Notices about hand hygiene techniques were displayed in staff and patient toilets. Curtains in consultation rooms were of the disposable variety and were changed every six months or when required.

Clinical staff had received inoculations against the risk of Hepatitis B. The effectiveness of this was monitored through regular blood tests and records had been kept. Clinical waste was handled correctly and a waste management contractor had been appointed to collect it on a regular basis. It was being stored safely prior to collection. Sharps bins were sited correctly, signed and dated.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

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.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was well equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the asthma clinic, and procedures, such as minor surgery.

Staff told us that all equipment was tested annually and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that relevant equipment such as blood pressure monitors and an electro-cardio gram (ECG) machine were regularly calibrated to ensure they were operating safely and effectively.

Staffing and recruitment

The practice had a recruitment policy that was sent to us in advance of our inspection. The policy set out the standards followed when recruiting clinical and non-clinical staff. The staff records we looked at during our inspection contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us they often rotated allocated duties to refresh their skills and ensure the smooth running of the practice.

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 manager told us there were systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included portable appliance testing and calibration of equipment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. However we saw that no health and safety checks or risk assessments had been undertaken of the building or the environment. In addition staff we spoke with told us they had not undertaken any fire drills. We discussed this with the practice manager who told us a full fire drill had been scheduled.

Health and safety information was displayed for staff to see and there was an identified health and safety representative, however the notice displayed was not the most current version. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis. Staff at all levels could share immediate concerns about risks to individual patients with a clinician. Staff we spoke with said they were confident they could recognise patients who might have acute needs requiring a clinician's input as a priority. However due to

Are services safe?

the lay out of the reception area, reception staff were unable to see patients in the waiting area and therefore would not be aware of any sudden deterioration in a patient's health or wellbeing.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in a secure area of the practice and staff we spoke to knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. 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.

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The plan included relevant contact information for local services and commissioners to enable rapid contact to be made with relevant organisations. The document was kept under review and we were told hard copies were located both on and off-site. The practice manager told us the practice was currently reviewing the business continuity plan. Not all staff we spoke with were aware of the plan or how to access it.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The practice manager told us staff were up to date with fire training; however staff had not undertaken a fire drill.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. We saw that practice management meetings included discussions on expected standards of care. New information or guidance from the Clinical Commissioning Group (CCG) prescribing committee or quality standards from the National Institute for Health and Care Excellence (NICE) were disseminated during these discussions. As a result, the practice's management plans and protocols for particular conditions or treatments were updated and put into practice.

The practice's daily, informal coffee meetings, held for all available clinical staff after the morning's surgery, also created a forum for staff to discuss clinical issues that had arisen during the morning's sessions.

The practice used their computer records system through the quality and outcomes framework (QOF) to identify and monitor particular patients within certain groups and to tailor any interventions according to their need. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services. For example, the practice identified and recalled patients with long term conditions so that their conditions could be monitored effectively. In this way the practice had also identified which of its patients were most at risk of unplanned hospital admissions and had developed individual care plans so that their care could be delivered proactively. The practice also employed a member of staff whose role was to 'track' information about such patients and to monitor their care plans. This was so their reviews could be carried out on time, any emerging risk factors could be identified early and interventions planned.

We also saw that the practice appropriately coordinated the multi-disciplinary team (MDT), comprising the community nursing team and the Macmillan service, for the planning and delivery of palliative care for people approaching the end-of-life. The MDT is part of the arrangements required by the quality standards for end-of-life care described by NICE. We saw that every patient receiving palliative care was reviewed by the MDT at formal monthly meetings to ensure that their specific needs were met. This was particularly effective at this practice since the community nursing teams were based on site and had opportunities to discuss individual patients' evolving needs face-to-face when required.

During our interviews with GPs and staff and throughout our observations we saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice were involved in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The practice had systems in place to monitor clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions.

The practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality. The outcomes of these searches were discussed at monthly clinical meetings. Our own examination of the QOF data showed that the practice was performing well across a range of attributes in comparison with the rest of the CCG area and England. We noted that national data, including data obtained from the QOF, showed that the practice was in line with expected standards and rates for identifying, registering, treating and prescribing for all conditions.

We saw that the daily and weekly clinical meeting played a key role in monitoring and improving outcomes for patients. As well as QOF information, we saw the clinical meetings considered significant events, complaints, medicine alerts and audits in order to inform the way the service was run. Our examination of a sample of the records of the clinical meetings for the year prior to our inspection showed examples where this information had been discussed.

There were a limited number of audits undertaken at the practice. The practice manager told us that due to the retirement of GPs at the practice over the previous year and the pressure on the remaining GP, recent regular clinical audits cycles had not been undertaken. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented in order to assess their effectiveness. We saw one audit cycle undertaken by the nurse independent/supplementary prescriber. Nurse independent prescribers are specially trained nurses allowed to prescribe any licensed and unlicensed medicine within their clinical competence. Nurse supplementary prescribing is based on a voluntary prescribing partnership between a GP and a nurse (supplementary prescriber) where the supplementary nurse prescriber has the ability to prescribe any medicine listed in a patient-specific clinical management plan once the patient has been diagnosed by the GP. The audit undertaken focused on contraceptive implant fitting over a one year period during 2014 and 2015. In March 2015 the audit reviewed the uptake of intrauterine devices over this period, patients who were offered pre-insertion counselling and the number of patients who attended post insertion for a three month follow up check. At review it was found that removal rates of devices had been low across the two clinical contraceptive implant fitters. It was felt this was due to patients receiving clear advice and counselling prior to fitting.

The practice participated in local benchmarking run by the clinical commissioning group (CCG). We noted that this process had enabled the practice to analyse referral data to local hospitals in areas such as X ray referrals, biochemistry and haematology tests (these are laboratory analysis of samples of blood or other body fluids or tissue, which give an indication to the GP of what is happening within the body). The practice were able to demonstrate that these were in line with other practices in the local CCG. We saw evidence to confirm that the practice worked with the local CCG medicines management team to monitor their prescribing behaviour and where required switch patients to a more cost effective medicine. For example the prescribing of oral contraception and antihistamines (these are medicines used in the treatment of hay fevers and allergies. The practice had also reviewed the level of prescribing of these medicines to ensure doses in line with national guidance.

There was a policy in place 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 GPs. We saw that the practice computer system alerted staff to relevant medicine alerts when the GPs or prescribing nurses were prescribing medicines.

Effective staffing

We looked at records and spoke with staff and found that staff were appropriately trained and supported to carry out their roles effectively. This was the case for both clinical and non-clinical staff. All of the GPs had their own areas of expertise which enhanced the service they were able to provide to their patient population. For example, one GP had expertise in musculoskeletal medicine and was a member of the British Institute of Musculoskeletal Medicine and The Society of Orthopaedic Medicine, another specialised in gynaecology, women’s health and homeopathy and had certificates in family planning, child health, gynaecology and obstetrics, whilst yet another GP had expertise in GP training and was a programme director for a local GP specialist training scheme. The GPs told us the practice locum GP had a wealth of experience and knowledge of Community Child Health, which they had supported and shared with clinical staff.

New staff received a comprehensive induction programme that introduced them to their role. Non-clinical staff were trained to carry out more than one role; for example, staff described how they would alternate the daily tasks to ensure they were refreshed and enable the practice to remain effective during peak times. We saw that all staff received regular training in subjects that are generally considered as key, such as annual basic life support training and annual safeguarding training. All the nursing staff were multi-skilled and had been trained in various aspects of practice nursing so that they, too, could cover the range of clinics that the practice ran. For example, advanced nurse practitioners (ANP) had undergone training in asthma care, management of chronic lung conditions and contraception. One ANP was a qualified paediatric nurse. The advanced nurse practitioners, practice nurses and health care assistant had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties.

The doctors and the nurses had maintained their continuing professional development requirements in order to ensure their continued registration with their relevant clinical professional bodies.

Good

Are services effective?

(for example, treatment is effective)

The practice had arrangements to provide clinical supervision which is an activity that brings clinicians of like professions and skills together. As we have referred to earlier in this report, the daily informal coffee meetings that took place mid-morning provided all clinical staff with the opportunity to discuss clinical issues that had arisen and from which learning could be obtained.

All staff received annual appraisals which identified their learning needs and other development opportunities. Staff appraisal schedules confirmed that these had taken place.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Discharge summaries, abnormal pathology results and letters from outpatients were all seen and actioned by a GP or an advanced nurse practitioner 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. However we were told that not all normal pathology results or treatment records for patients who had used the out of hours/111 service were reviewed by the GPs, with some GPs requesting these were triaged by non-clinical administration staff and filed directly to the patients record. This meant that the practice could not be sure patients' information was reviewed by a clinician and, where required, patients received timely and appropriate treatment.

We found that the practice engaged regularly with other health care providers in the area such as the district nursing team, the health visitors, mental health link workers, the emergency department of the local hospital and the local ambulance service. The practice held bi-weekly informal meetings with the health visitors and midwives to identify and discuss families that might need additional support. The evolving needs of every patient receiving palliative care were discussed at monthly multi-disciplinary team (MDT) meetings. As patients neared the very end of life, their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service to ensure that specific wishes about their death could be met. We saw that the meetings not only looked at the needs of the individual patient but also the needs of their families and carers.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

Electronic systems were in place for making referrals, such as 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. For emergency patients, a printed copy of a summary record could be provided for the patient to take with them to A&E. For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

GPs and nurses at the practice worked closely with other health care professionals and agencies who support people with life limiting illnesses. Records we saw showed that multidisciplinary meetings took place at the practice monthly with a range of other health professionals in attendance to co-ordinate care and meet the needs of the patients. GPs met with other health care services to ensure that care and support was delivered in a co-ordinated way that met patients changing needs.

The practice took part in the falls prevention scheme; vulnerable elderly patients who were most at risk of falls had been identified and a care plan created which identified the patient's carers, social services and community nursing team and next of kin. The practice had systems for making information about patients with complex care needs, such as those receiving end of life

Are services effective?

(for example, treatment is effective)

care, available to the out of hours service. The information included the patient's preferred place of care and resuscitation preferences to ensure the practice was able to comply with the patient's choices.

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 trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

However as we have detailed earlier in this report we were told that not all normal pathology results and treatment records for patients who had used the out of hours/111 service were reviewed by the GPs, with some GPs requesting these were triaged by non-clinical administration staff and filed directly to the patients record. This meant that the practice could not be sure patients' information was reviewed by a clinician and where required patients received timely and appropriate treatment.

Consent to care and treatment

We found that patients' consent to care and treatment was always sought in line with legislation and guidance. This consent was either implied, in respect of most consultations and assessments or was explicitly documented, in the case of, for example, minor surgical procedures or the fitting of an intrauterine contraceptive device. For such procedures the practice used template forms that were taken from the practice computer system. These forms explained the procedure or process in detail to enable patients to fully understand their treatment. Patients we spoke with on the day of our visit told us that they were always provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

We also saw that the practice applied well-established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. We also saw that the provisions of the Mental Capacity Act 2005 were used appropriately and that assessments of patients thought to have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. This was particularly relevant for patients who had a learning disability or who lived with dementia. Not all the staff we spoke with told us they had received training in the Mental Capacity Act; however we were shown that relevant guidance to support staff was available on the practice's computerised document system.

Health promotion and prevention

We saw that all new patients were asked to complete a general health questionnaire when they first registered and were invited into the surgery to see a healthcare assistant for a health check and exploration of their medical history and lifestyle. All patients over 40, including those also over 75, received a NHS health check by healthcare assistants that had been trained to carry this out. Patients prescribed medicines or with long term conditions were referred to the GP for review.

The practice ran health promotion clinics for long term conditions such as diabetes, asthma and heart disease and these were advertised in the practice information leaflet and on the practice web-site. Clinics were also held for smoking cessation, blood pressure monitoring and weight management. We saw that there was also information available about long term conditions on the practice web-site as well as information about promoting family health. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and a dedicated smoking cessation clinic. The practice were able to show that 99% of patients who smoked had been referred for smoking cessation advice.

The practice also provided a full range of childhood immunisations and nationally collected data showed that they were in comparison with the rest of the CCG area. The same national data showed that the practice achieved expected take up rates for cervical smears and influenza vaccines, as well as for those patients living with dementia who had received a face-to-face review of their health needs.

As reported above, the practice used a risk identification tool to identify patients that were most at risk of repeated hospital admissions. The practice managed the care of these patients, as well as those receiving end-of-life care, through individually tailored, proactive shared care plans on a multi-agency basis.

Good

Are services effective?

(for example, treatment is effective)

We noted that the practice web-site had an informative section with links to other organisations or to information about long-term medical conditions.

Patients who required extra support were identified and care was tailored to meet their needs. For example, patients we spoke with on the day of our inspection whom had particular, significant long-term health needs told us that the practice had managed their care well and had explored ways of minimising the effects of their illness. Furthermore, we saw that patients who were receiving palliative care were discussed at monthly MDT meetings where the effectiveness of their individualised care plans was considered. The practice had a carer’s register which ensured that people who were looking after others were identified, offered the opportunity for additional support and referred onwards to other services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. We spoke with eight patients on the day of our inspection. All of the patients we spoke with reported that their GP, the nurses were courteous, considerate and compassionate. Patients also told us that all the reception staff were polite and had a pleasant manner with patients. This was borne out during our observations in the reception area when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk.

Staff told us patients could be taken to a quiet room to the side of the reception if they wanted to speak in private to a receptionist or the practice manager. We noted music playing in the reception area was used to prevent patient conversations being overheard in the waiting area.

We also reviewed 11 comment cards that had been collected from patients in advance of our visit. None of the comment cards indicated any negative or critical opinions; however one card commented that it could sometimes be difficult to make an appointment with a specific GP. All of the cards reported wholly positive experiences of patients. Some of the cards referred to GPs and staff by name, singling out individual examples of kindness, care and compassion.

We looked at data from the 2015 National Patient Survey, carried out on behalf of the NHS and reported on the NHS Choices web-site. We noted that 69% or patients stated they would recommend the practice this was among the lower range of ratings nationally. However 83% stated that they felt the practice was good or very good. 85% of patients reported that the reception staff were helpful with 95% reporting they had confidence and trust in the last GP they saw or spoke with. This was in-line with local CCG and national average. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (88%) and by their doctor (85%). This was in-line with the comment cards we reviewed, the views of the patients we spoke with during our visit and our observations throughout the day.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Nursing and other clinical staff were primarily used as a chaperone. If nursing staff were not available to act as a chaperone receptionists undertook this role. We were told reception and administration staff had undertaken training to perform this role. As we reported earlier not all staff we spoke with were comfortable with the training and did not feel they understood their role. Female patients we spoke with confirmed that they had been offered a chaperone.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey showed that, on average, 86% of patients felt the GPs were good giving them enough time, 88% felt the GPs were good at listening to them and 87% felt the GPs were good at explaining test results to them. 81% of patients felt that the GPs were good at involving them in decisions about their care with 95% stating they had confidence and trust in the last GP they saw. These satisfaction rates were in-line for both the local Clinical Commissioning Group (CCG) area and for England in general. The corresponding figures for the nursing staff were similar with 96% of patients stating they had confidence and trust in the last nurse they saw.

All eight of the patients we spoke with on the day told us that both the nursing staff and the GPs gave them enough time and provided sufficient information to enable them to understand their care and treatment. Patients said they felt in control, involved in their treatment planning and had the opportunity to ask plenty of questions if they were unsure. Similarly, none of the 11 comments cards we reviewed reported negative experiences of patients in relation their involvement whilst several overtly stated that they felt involved.

We found that patients who were referred onwards to hospital or other services were involved in the process. Doctors we spoke with told us that referrals on the 'choose and book' system were made with the patient still in attendance. Patients and staff we spoke with confirmed that this was the case.

The practice also had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment although this service was used very rarely. There

Are services caring?

was no hearing loop at the practice for patients with reduced or limited hearing, however staff were very aware of those patients with reduced hearing and told us the patients used lip reading and written communications to liaise with staff.

Patient/carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved. For example, there was a board in the private, staff area of the practice that alerted staff to the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

Furthermore, relatives of patients who had died were called by the practice and offered a visit by one of the GPs, the purpose of which was to assess their emotional and support needs and to offer a referral to local counselling or bereavement support services.

The care plans of people receiving end-of-life care, those patients who were most at risk of unscheduled hospital admissions and patients with particular complex health needs including children were discussed at monthly multi-disciplinary team (MDT) meetings. This ensured that the practice could regularly and actively monitor the evolving needs of these groups of patients.

The practice actively took steps to identify patients who were carers. This group of patients were provided with information about local services providing practical and emotional support and referrals to these services were actively managed by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice made use of an alert system on the computerised patient database to help them to identify patients who might be vulnerable or have specific needs This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care or those who were recently bereaved. The alert system also identified individual patient's risk to enable clinicians to consider issues for their consultations with patients, such as children who were known to be at risk of harm.

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and opportunistic smoking cessation advice.

The practice had identified those patients who were at risk of unplanned admission to hospital and had tailored, individual care plans to meet their needs. This enabled the practice to actively monitor and treat those patients to mitigate the risk of attendance at A&E. In addition the practice had identified a number of housebound patients with a number of long term health conditions. We were told the practice nurse had visited 30 of these patients in their homes and had undertaken full health check. This had given an opportunity for the practice to identify other potential issues such as mobility in the home and put systems in place to improve these patients quality of life as well as reviewing their health needs.

The practice did not have an active patient representation group (PRG) but was in process of recruiting to a virtual group. A patient representation group are a group of patients who work with the practice staff to represent the interests and views of patients, to improve the service provided to them. A virtual group liaises with the practice via email. Although there was no PRG in place, the practice had nonetheless completed annual patient surveys, to obtain and act on patients' views to improve the service. We saw evidence that the practice had responded to feedback from patients. For example, we saw that the practice offered early morning and late evening extended hours appointments twice a week in response to feedback from patients who due to work and school commitments were unable to attend the practice during usual opening hours. The practice should note that these extended hours were not shown on the practice web-site.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of patients living with dementia. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review. Moreover, we saw that the practice ran regular checks of the data on their patient record system to identify patients with a range of factors that were particular indications of a learning disability or of dementia so that they could benefit from this service.

We also saw that the premises were configured in a way that enabled patients in wheelchairs to access their GP. There was level access throughout with widened doorways and an accessible toilet. We learned that particular arrangements were made for a patient who required assistance due to their specific disability.

We saw that the practice web-site had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information about the practice and about NHS primary medical care. We saw that interpreters were arranged in advance and that extended appointments were booked to facilitate this on the infrequent occasions this occurred.

Patients who were short term visitors to the area, such as members of the travelling community, could access care where this was immediately necessary and by registering as a temporary resident.

Access to the service

The practice offered appointments that could be booked up to ten weeks in advance for GPs and nurses. Additional appointments were also released in stages as well as on-the-day. Patients could book appointments over the telephone, in person or by registering to use an online facility governed by the practice's electronic patient record system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients who wished to be seen in an emergency were offered an appointment slot towards the end of surgery opening times. The practice also offered telephone consultations where patients needed to speak with a GP, but they could be called in to attend if their problem was subsequently found to require a face-to-face consultation. GPs carried out home visits to patients who were not able to get the practice and as mentioned earlier the practice nurse carried out home visits for health checks for housebound patients with long term conditions.

The practice was open from 08:00 to 18:30 Monday to Friday. The practice was located in an area which has a slightly higher than average proportion of working age people. In order to meet the needs of this group of patients and in response to patient demand the practice offered extended appointments outside of normal scheduled hours. These extended hours were between 7am and 8am every Tuesday morning and between 6:30pm and 7:30pm every Thursday evening.

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.

We were told GP appointment slots had been increased from 10 minutes to 15 minutes to ensure patients were not rushed during their consultation. 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.

The 2015 National Patient Survey results showed 77% of patients responding to the survey were satisfied with the practice opening times with 85% reporting they were able to get an appointment or see and speak with someone on the day. On the day of our inspection, all eight of the patients we spoke with said that they were happy with the appointment booking system. There were no concerns or critical comments about the appointment system on the 11 comment cards we received. Several patients commented positively about appointment availability. However one comment card raised concerns about the appointment availability of their GP of choice. Patients confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another clinician if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice listened to patients' concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was 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. There was information on the practice website, and in leaflet form in the reception area advising patients of the complaints procedure. All of the patients we spoke with said they had never had cause to complain told us they would know how to complain if necessary.

We looked at the complaints received in the last twelve months and that these had been satisfactorily managed and dealt with in a timely way.

The practice reviewed complaints on an on-going basis and reviewed these regularly at partner and team meetings. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. We saw an example where, following a complaint, the practice was working to improve the availability of on-line appointments.

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 completed a Statement of Purpose as required by the Health and Social Care Act 2008. The staff we spoke with told us the practice's main priority was to deliver best possible patient care but they were not aware of a practice vision or strategy. The staff placed high value on staff stability, understanding the needs of patients and continuity of care. They said there was a supportive and friendly culture among the staff. Staff also noted there had been a greater emphasis on improving the service more recently, each staff member we spoke with were clear that they treated patients with respect, they listened to their concerns and they respected patient privacy and dignity.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs.

Governance arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. The practice had identified a lead clinician for each specialist clinical area, such as coronary heart disease, diabetes, chronic lung conditions and people approaching the end of their lives. They were responsible for providing clinical direction to the practice's approach to these conditions.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The QOF is a database used by GPs to measure their performance against certain criteria that affects the way practice was funded.

The practice also actively used feedback from patient surveys, complaints, concerns and the findings of significant event analyses (SEA), clinical audits and peer reviews of referrals made and their outcomes in order to understand and manage any risks to their service. We looked at a number of examples of each of these as previously set out in this report.

In addition, the practice ran daily mid-morning clinical coffee meetings which enabled clinical staff to discuss issues as and when they arose, or to put aside for more thorough consideration at a more formal meeting. The staff team were briefed about any changes as and when they occurred.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice mission statement of providing the best possible healthcare within its means. The partners in the practice were visible and staff told us that they were approachable and always took the time to listen to all members of staff. Staff were clear about their own roles, but we found there was some uncertainty among the staff members we spoke with about the frequency of staff meetings. There were few notes of these meetings so it was not clear how all staff were involved in decision making and learning outcomes across the practice. We noted however, that the practice kept staff appraised of decisions by way an 'electronic memo' from the practice manager, although there was no culture of consultation or challenge in which staff could contribute to the direction of the practice.

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 annual surveys and complaints received. The practice manager showed us the analysis of the last patient survey. The results and actions agreed from these surveys were available on the practice website.

As previously set out in this report the practice did not have an active patient representation group (PRG) and was in process of recruiting to a virtual group. A patient representation group are a group of patients who work with the practice staff to represent the interests and views of patients, to improve the service provided to them. A virtual group liaises with the practice via email. Although there was no PRG in place, we found the practice listened and responded in a timely way to formal and informal feedback from patients. The practice had completed annual patient surveys, to obtain and act on patients' views to improve the service. We saw evidence that the practice had responded to feedback from patients. For example, we saw that the practice offered early morning and late evening extended hours appointments twice a week in response to feedback from patients who due to work and school commitments were unable to attend the practice during usual opening hours.

Are services well-led?

Good

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

As previously set out earlier in this report the practice featured a daily, informal mid-morning coffee meeting that took place for a short time mid-way between the morning's surgeries. All available medical and nursing staff attended. Any incidents and concerns arising from the morning's work were discussed and dealt with immediately or escalated for further investigation or more detailed discussion in a more formal process. The practice had also gathered feedback from staff through appraisals and discussions.

The practice held multidisciplinary clinical meeting once a month that were attended by the GPs and nurses. There were informal management meetings where complaints, significant events and safety issues, amongst other things, were discussed. The practice told us that the meeting's structure was a little ad hoc and minutes were not routinely recorded. As a small practice they shared information on an informal basis and when speaking with staff we were assured that relevant issues had been discussed with them. Due to the absence of minutes this could not be evidenced by the practice and where learning had been identified and improvements made there was no audit trail to confirm they had taken place. The practice recognised this as an area for improvement and was open with us about this issue.

Staff we spoke with were clear about their roles and responsibilities, and felt that the practice was generally well led. They also said that they felt valued and supported. Staff described the culture of the organisation as supportive, however not all the staff we spoke with felt they were involved in the practice or felt comfortable to raise all issues with senior managers. A whistleblowing policy was in place, however not all the staff we spoke with were aware of this, staff told us they had not had cause to use it.

Management lead through learning and improvement

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

We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw that there were immediate and daily reviews of issues as opposed to trends or theme analysis. However, all incidents were known to staff who had an extensive organisational memory.

Records showed that GPs and nursing staff were supported to access on going learning to improve their skills and competencies. For example, attending specialist training and opportunities to attend external forums and events to help ensure their continued professional development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The providers must do all that is reasonably practicable to mitigate risk and ensure that safe and clinically supervised systems are in place for the review of all patient correspondence. They should follow up best practice guidance and must adopt control measures to make sure the risk is as low as reasonable possible. This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.