Dr N A Nayyar and Partners - Riverside Medical Centre

Quality Report

Riverside Medical Centre
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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.

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Overall summary

Riverside Medical Centre is registered with CQC to provide primary care services, which includes access to GPs, minor surgery, family planning, ante and post natal care. It provides GP services for 10,753 patients living in the Castleford area. The practice has five GP partners, a salaried GP, a senior nurse manager, a nurse practitioner, a triage nurse, four practice nurses and three healthcare assistants. It is a teaching practice and had a trainee GP in post at the time of the inspection.

The practice is open Monday to Friday from 8am to 6pm. Patients can book appointments in person, via the phone and online. The practice provides a triage service so patients can discuss their condition with a nurse who, depending on the patient's symptoms, either advises on treatment or arranges an appointment with one of the practice's clinicians. The GPs also provide telephone consultations each afternoon. The practice treats patients of all ages and provides a range of medical services.

The practice is registered with the Care Quality Commission to deliver the regulated activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

The practice had a very good track record for maintaining patient safety. They worked collaboratively with five other practices in the area to look at how they could continually improve the service and learn lessons from any incidents that had occurred in the patch.

The patients we spoke with and who completed the CQC comment cards were extremely complimentary about the care and treatment being provided.

Staff were responsive to patients' needs. They had set up and maintained a very active patient participation group (PPG) and readily listened to their views and suggestions.

The building was well-maintained and very clean. Effective systems were in place for the oversight of medication. Clinical decisions followed best practice recommendations.

We found that the leadership team was very visible. There were good governance and risk management measures in place.

The practice safely and effectively provided services for all patient groups. The staff were caring and ensured all treatments being provided followed best practice guidance.

We found that the practice had met the regulations and provided services that were safe and effective.

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 service was safe. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to provide constant oversight of safety of the building and patients. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding referrals.

Are services effective?

The service was effective. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice was a teaching practice and provided placements for trainee doctors. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met. Consent to treatment was always obtained appropriately.

Are services caring?

The service was caring. The five patients who completed CQC comment cards and 18 patients we spoke with during our inspection were extremely complimentary about the service. They all found the staff to be extremely person-centred and felt they were treated with respect. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or an advocate were involved in helping patients who required support with making decisions.

Are services responsive to people's needs?

The service was accessible and responsive to patients' needs. The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter alerting patients with a hearing impairment. Staff were knowledgeable about interpreter services for patients were English was their second language. The practice responded appropriately to complaints about the service. Regular patient surveys were conducted and the practice took action to make suggested improvements.

Are services well-led?

The service was well led and effectively responded to changes. Governance and risk management structures were in place. The practice had a clear vision and set of values which were understood

Summary of findings

by staff and evident on the practice website. Staff were committed to maintaining and improving standards of care. The team used their clinical audit tools, clinical supervision and staff meetings to assess how well they delivered the service and make improvements.

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 was knowledgeable about the number and health needs of older patients using the service. The practice actively reviewed the care and treatment needs of older people and ensured each person who was over the age of 75 had a named GP. Medication reviews were completed with all patients over the age of 75. They kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner.

We heard from patients in this age group that they had always been able to see their named GP and that the triage nurse was very accessible and remembered them. They found that all the staff were extremely helpful. We found the practice worked well with other agencies and health providers to provide support and access specialist help when needed.

People with long-term conditions

All of the staff had a very good understanding of the care and treatment needs of people with long-term conditions. The practice closely monitored the needs of this patient group and promoted approaches the patient could use to improve their quality of life. We heard from these patients that staff invited them for routine checks and to remind them of appointments at the clinics.

We found staff had a programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was always being followed.

Mothers, babies, children and young people

The practice provided services to meet the needs of this population group. There were comprehensive screening and vaccination programmes which were managed effectively to support patients. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns.

All of the staff were very responsive to parents' concerns and ensured parents could readily bring children into the practice to be

Summary of findings

seen who appeared unwell. The triage nurse had an in-depth knowledge of symptoms for childhood and adolescent illnesses and used this to direct parents to the most appropriate healthcare resource.

The working-age population and those recently retired

The practice provided a range of services for patients to consult with GPs, triage nurse and nurses, including on-line booking and telephone consultations.

The practice had developed a solid information base which covered the needs of their entire patient group. Staff had a programme in place to make sure no patient missed their regular reviews for their condition such as diabetes, respiratory and cardiovascular problems. Appointments were available prior to 9am and after 5pm.

People in vulnerable circumstances who may have poor access to primary care

Some of the staff had completed specific training around working with people who had a learning disability and ensured this group got a fair access to care. The practice made adjustments to how they provided the service in order to meet patients' needs. For example, the practice offered longer appointment times for patients with a learning disability. This helped to ensure patients were given time to be fully involved in making decisions about their health.

The practice were very aware of patients in vulnerable circumstances and actively ensured these patients received regular reviews, including annual health checks. We found that all of the staff had a very good understanding of what services were run within their catchment area such as supported living services, care homes and families with carer responsibilities.

Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in the last 12 months.

People experiencing poor mental health

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

The GPs proactively ensured they were up to date with the latest developments for people with mental health needs. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision.

Summary of findings

All of the staff had a very good understanding of patients' social background, conditions and personal attitude towards their health. They used this information when taking calls and talking to patients in the reception area.

Summary of findings

What people who use the service say

We received five completed patient CQC comment cards and spoke with 18 patients who were using the service on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical conditions and long-term care needs. The patients were extremely complimentary about the service. Patients told us that they found the staff to be extremely person-centred and felt they were treated with respect.

The national GP survey results published in December 2013 stated the practice were found to be similar to expected nationally. Areas that indicated a poorer response rate related to access to timely appointments and variation in the ability of nurses and GPs. The national GP survey results published in July 2014 showed that 83% of patients said it was easy to get through to the practice to make an appointment, 80% of respondents were satisfied with opening times and 83% patients found it easy to see a clinician, and these are significant improvements and brought them in line with good ratings for practices nationally. Patients and representatives from the patient participation group (PPG) told us that the practice had acted on this feedback and made significant improvements to the appointment system. All of these patients commented that they could now readily make an appointment both for the day and in advance. Over the last year five comments have been made by patients on the NHS choices website and these were in respect of their very positive experience of the service. Patients we spoke with were very complimentary about the service the triage nurse provided and liked the fact that the GPs completed telephone consultations.

In response to feedback from the patients and PPG they had altered the appointment system. Patients could phone during the day and speak with the triage nurse who could offer advice, treatment options or organise an appointment with the GPs. The GPs routinely provide afternoon access to telephone consultations each afternoon as well as face-to-face appointments. Patients could also make bookings for up to a month in advance.

We spoke with a representative of the patient participation group (PPG). They told us they were confident their views were listened to and felt they had a contribution to make in service improvement. They felt the PPG members worked well together and were an important part of the practice system for making sure the service operated well. They also told us that the lead GP had encouraged them to forge links with other PPGs in the area, which they had done and this proved to be very useful for sharing ideas and looking at the effectiveness of their service.

Patients we spoke with told us they were fully involved in deciding the best course of treatment for them. They all told us this was the best practice in the area. Patients were extremely satisfied with the availability of appointments and told us that, when needed, the GP called them in the afternoon via telephone consultation. The patients told us the GPs had been able to organise for prescriptions to be sent to the pharmacist on the day they had telephone consultations. They told us that the nurses were very responsive and they could readily get appointments to see them. They also told us that they could get their repeat prescriptions the same day, which they found was a wonderful resource.

The national GP survey results published in July 2014 showed that 86% of patients said the GP's gave them enough time and 79% of respondents felt the nurses gave them enough time to discuss their condition. However 86% of patients said they their overall experience was good.

Patients told us that the staff were all committed to providing the best care possible and really cared about their wellbeing. Patients discussed how the GPs had been extremely supportive. They all told us the doctors and nurses were extremely competent and knowledgeable about their treatment needs. They told us that the service was exceptionally good and their views were valued by the staff.

Summary of findings

Areas for improvement

Outstanding practice

Our inspection team highlighted the following areas of good practice:

There were excellent systems for conducting clinical audits and monitoring the practice in place that provided assurance that the services provided met people's needs, treated them effectively and minimised the risks associated with illnesses and treatment.

Clinicians critically reviewed their practices and this had led to not only changes in their own working practices but also that of other organisations. For example the GPs had worked with a cluster of five GPs practices to review responses to significant events. Within this cluster they had ensured that robust and challenging critique of practice was a consistent feature of the work undertaken and completed case reviews of all significant events.

The practice's prescription services were refined to enable patients to obtain their repeat prescriptions on the same day as they requested them.

The practice had a very easy to follow system for prompting patients to make appointments when medication needed to be reviewed.

The practice had a very active voice in shaping services for their patients in the local area. For example following the need to move the breast screening unit from their car park to a new location they had monitored uptake rates for breast screening and found it was much reduced so suggested to the Trust a more accessible site in a shopping centre. The Trust took this on board and the practice found uptake rates were now higher than previously recorded.

Practice participation group members told us that the lead GP had encouraged them to forge links with other PPGs in the area, which they had done and this proved to be very useful for sharing ideas and looking at the effectiveness of their service.

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Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and the team included a GP, a practice manager and an expert by experience who is someone that has used health and social care services.

Background to Dr N A Nayyar and Partners - Riverside Medical Centre

Riverside Medical Centre registered with CQC to provide primary care services, which includes access to GPs, minor surgery, family planning, ante and post natal care. It provides GP services for patients living in the Castleford area. The practice has five GP partners, a salaried GP, a senior nurse manager, a nurse practitioner, a triage nurse, four practice nurses and three healthcare assistants It is a teaching practice and had a trainee GP in post at the time of the inspection.

The practice is open Monday to Friday from 8am to 6pm. Patients can book appointments in person, via the phone and online. The practice provides a triage service so patients can discuss their condition with a nurse. The GPs also provide telephone consultations each afternoon. The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients access West Yorkshire Urgent Care Services.

The practice is part of NHS Wakefield Clinical Commissioning Group. It is responsible for providing primary care services to 10, 753 patients. The male patient population of the practice is 49.5 %., 15.5% of all patients are over 65 years of age. The largest population group for the practice is the 20-65 years age group which is 64.5%.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This practice had not been inspected before and that was why we included them in this programme of inspections.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the 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 carried out an announced inspection on 08 July 2014 and spent eight hours at the practice.

We reviewed all areas of the practice including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, registered manager, a GP, a GP trainee, the triage nurse, two nurses, four administrative staff, the clinical lead for infection control and two receptionists on duty. We spoke with patients who were using the service on the day of the inspection and with the chair of the patient participation group.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Are services safe?

Our findings

Safe Track Record

Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as an achieving practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We looked at a recent significant event from February 2014 which had been reported to NHS England using the incident reporting system.

The practice had systems in place to monitor patient safety. The practice manager, GPs and nurses discussed significant events and showed us documentation to confirm that incidents were appropriately reported. GPs discussed them at their weekly meetings and at meetings with their cluster of five other practices. Action was taken, not only at this practice but across the cluster to learn lessons and put measures in place to reduce the risk of the event recurring in the future. We saw that apart from reviewing incidents individual GPs also completed evaluations of the changes their practice made to outcomes for people. For example one GP, in line with guidance completed condition specific audits on treatment offered to patients with long-term conditions. In addition to this a two yearly evaluation cycle would be undertaken to determine whether changes to practice had been sustained and had improved access for patients.

Staff provided us with evidence to show that they actively reported any incidents that might have the potential to adversely impact patient care. Staff told us that they viewed this process as a positive process to ensure they provided excellent patient care. Staff could readily describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose. Concerns regarding the safeguarding of patients were passed on to the relevant authorities as quickly as possible.

The practice minutes of meetings we reviewed show that new guidelines, complaints, incidents and significant events, were discussed at each meeting. The staff we spoke with were very positive about the use of incident analysis and how this assisted them to develop the care provided. The clinicians were confident that the treatment approaches adopted followed best practice and this was confirmed in our discussions with clinicians.

The practice manager told us they ensured reports about incidents, significant events and complaints were also taken to the monthly board meeting. The board was responsible for the running of the practice. This helped ensure there was shared learning from incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw evidence to confirm that staff had completed a significant event analysis which included identifying any learning from the incident.

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. GPs told us significant event audits 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. The team recognised the benefits of identifying any patient safety incidents and near misses.

We saw good examples of this review process which staff had not only used to improve treatment delivery in the practice, but also to change practices within secondary care. For instance the Trust's breast screening mobile service had been relocated from the practice car park to another spot in Castleford. The practice staff had tracked uptake rates for their patients at this new location and found it had fallen significantly. They alerted the Trust and made a suggestion that it was sited in a local retail park. The Trust had taken on board this advice and the practice had continued to monitor the situation and found that numbers of their patients now attending for screening now exceeded levels previously found when in was in the practice's car park.

From the review of compliant investigation information we saw that the practice manager and GP partners ensured complainants were given full feedback and asked for

detailed information about their concerns. We saw that the practice then checked if the complainant was happy with the outcome of the investigations and any actions made to improve the service.

Reliable safety systems and processes including safeguarding

The practice had up to date 'child protection' and 'vulnerable adult' policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff on their computers. Staff had access to contact details for both child protection and adult safeguarding teams. The trainee doctor we spoke with confirmed they had access to the practice's safeguarding policies and procedures on the practice intranet.

Staff, including trainee doctors, had received training in the last 12 months. They were knowledgeable about the types of abuse to look out for and how to raise concerns. For example, the practice manager and GPs told us about child protection and safeguarding concerns they had recently raised. Also administrative staff told us about concerns they had raised with the GPs and how these had been followed up immediately.

Staff were readily able to discuss what constituted a child and adult safeguarding concern. They told us about incidents when they had either raised safeguarding or child protection alerts and showed us associated alert forms to confirm this had occurred.

One of the GPs took the lead for safeguarding and had attended appropriate training to support them in carrying out their work, as recommended by professional intercollegiate safeguarding guidance. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and serious case reviews. The safeguarding lead attended local case conferences and completed reports when necessary.

When safeguarding concerns were raised staff ensured these alerts were put onto the patient's electronic record. Staff were proactive in monitoring if children or vulnerable adults attended Accident and Emergency or missed appointments frequently. These were brought to the GPs attention, who worked with other health professionals such as health visitors, midwives and district nurses. This meant that people were protected from harm and children and vulnerable adults had the risk of abuse minimised.

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. The GPs told us significant event audits were also included in their appraisals in order to reflect on their practice and identify any training or policy changes required for them and the practice. The team recognised the benefits of identifying any patient safety incidents and near misses.

From our discussions we found that GPs were very aware of the latest best practice guidelines and incorporated this into their day-to-day practices. We saw there were effective systems in place to ensure the staff remained up to date with the latest developments. For example at each clinical meeting GPs discussed changes to guidance, clinical audits reviewed implementation of latest best practice and staff regularly attending clinical conferences.

Monitoring Safety & Responding to Risk

The Practice has a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment and equipment. Any risks were discussed at GP partners meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team and worked through how to address the recommendations.

The practice manager had procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The administration manager told us they were responsible for producing the rota, approving annual leave and for ensuring there were sufficient reception staff on duty each day. The practice had recently reviewed the duties for reception staff and highlighted were additional staff would improve the service, as a result they had created a new post within the nursing department whereby an administrator was employed to write up notes and letters and to check that all reviews were completed in a timely manner. Also the practice had employed an apprentice to support staff in carrying out their work.

The practice manager and lead 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 daily the telephone consultations sessions. The reception manager told us this gave additional flexibility to cover vacancies, absences or meet increased demand, for example after a bank holiday.

The PPG meeting minutes highlighted that the GP partners shared the lessons they had learnt around actions that could be taken to improve the service with them. The PPG representative told us that the practice had made their group feel full members of the management system and were integral partners in looking at how the service could be developed and improved.

We found checks were made to minimise risk and best practice was followed. These included monitoring staff refresher training to ensure they had the right skills to carry out their work and monitoring stocks of consumables and vaccines to ensure they were available, in date and ready to use. The clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis shock. Staff that would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experience a cardiac arrest.

Management of medicines

There were clear systems in place for medicine management. The GPs re-authorised medication for patients on an annual basis or more frequently if necessary. The practice had developed a very visual way of alerting patient who received repeat prescriptions of the need to book in for a medicine review. This involved the use of reminders on green and red paper attached to their prescription. Staff found this system was very effective and we observed patients booking appointments in response to the note on their prescription.

The practice worked with pharmacy support from the Clinical Commissioning Group (CCG) to support the clinical staff in keeping up to date with medication and prescribing trends. The CCG pharmacy support visited the practice three times a week. From our review of documents we saw that there were up to date medicines management policies in place. The staff we spoke with were familiar with them. Medicines were kept securely and could only be accessed by the clinical staff and Clinical Commissioning Group (CCG) pharmacy support. There were appropriately stocked medicine stores and equipment bags ready for doctors to take on home visits. We saw evidence that the bags were regularly checked to ensure that the contents were intact and in date.

Clear records were kept whenever any medicines were used. Arrangements for the storage and recording of controlled drugs or medicines that require extra checks were followed. All medicines we checked were in date, and staff ensured stock was used in a systematic order. Any changes in medication guidance were communicated to clinical staff in person and electronically via the webform for prescriptions. This ensured staff were aware of any changes and patients received the best treatment for their condition.

GPs reviewed their prescribing practices as and when medication alerts were received. We noted that within the practice clinical meetings GPs and nurses were sharing latest guidance on changes to medication and prescribing practice. Centrally the medicine management staff monitored the practice to ensure reviews of medication were completed with patients in a timely manner. GPs and staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to critically evaluate their practices and the service being provided.

There were standard operating procedures (SOP) in place for using certain drugs and equipment. The nurse prescribers used patient group directions (PGD) when deciding what medicines to prescribe. These documents ensured all clinical staff followed the same procedures and nurses who prescribed medication did so safely. The SOPs and PGDs were reviewed, were in date and clearly marked, which ensured staff knew it was the current version.

Prescription pads and repeat prescriptions were stored securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. They were also able to describe the additional checks required when giving out prescriptions for controlled drugs.

Cleanliness & Infection Control

Patients commented that the practice was clean and appeared hygienic. The practice arranged for an external company to regularly complete infection control audits. We saw that action had been taken to ensure the overall cleanliness of the building was good. Cleaning schedules were in place including a record that the tasks were carried

out. We saw that a schedule was in place to make sure each area was thoroughly cleaned on a regular basis. The practice was cleaned in line with infection control guidelines.

We spoke with the nurse who had the lead role for infection control and found her to be extremely knowledgeable. We found the practice had a comprehensive system in place for managing and reducing the potential for infection.

We inspected all the treatment and clinical rooms. We saw that all areas of the practice were very clean and processes were in place to manage the risk of infection.

There was an up-to-date Infection Control Policy in place. A needle stick policy was in place, which outlined what to do and who to contact. We saw updated protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice. Spillage kits were available in the locked sluice room. This meant staff could readily deal with all eventualities.

Infection control training was part of induction for all staff (including hand washing). Clinical staff completed this training at induction and then refresher training on an annual basis. Non-clinical staff completed the training during their induction and had access to the information produced by the infection control lead.

We observed good hand washing facilities to promote high standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/ consulting rooms and in reception. Couches were washable, curtains around them were disposable and there was easy clean flooring in treatment areas.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. Checks were carried out and recorded to ensure items such as instruments, gloves and hand gel were available and in date. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

Staffing & Recruitment

The provider recruitment policy was in place and up-to-date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service. We looked at a sample of recruitment files for doctors, administrative staff and nurses. We saw that the practice independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists. The practice manager also obtained health statements for all employees so they knew the person was physically and mentally able to perform their role. The recruitment procedure ensured appropriate staff were employed.

We saw that as a routine part of the quality assurance and clinical governance processes the provider checked the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists each year to make sure the doctors and nurses were still deemed fit to practice.

The GP partners and practice manager had agreed in conjunction with commissioners what would be safe staffing levels and the rotas showed that these were consistently maintained. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses had been allocated lead roles such as for infection control, respiratory disease, mental health, learning disability and the Mental Capacity Act 2005. We found that the practice manager and senior staff monitored how effectively lead staff fulfilled their role. This included routine checks to ensure that GPs and nurses were using the latest guidance and protocols. Findings were routinely analysed and any emerging risks were immediately fed back to the staff so action could be taken to improve service delivery.

Dealing with Emergencies

Comprehensive plans to deal with any emergencies that may occur, which could disrupt the safe and smooth running of the practice were available. A detailed business continuity plan was in place, which was reviewed in June 2014. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs. Reception staff we spoke with were knowledgeable about the business continuity plans and described how they had used the plan when telephone and IT systems failed.

Are services safe?

Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR) and other emergencies such as fire and floods.

Equipment

The practice manager had contracts in place for annual checks of fire extinguishers, 'portable appliance testing' and calibration of equipment.

Emergency drugs were stored in a separate locked cabinet and vaccines were stored in a vaccine fridge. Temperature logs for the vaccine fridge were accurate and complete. A log of maintenance of clinical and emergency equipment was in place and there was a record noted on the log when any items identified as faulty were repaired or replaced.

We saw that the provider had contracts in place for portable appliance tests (PAT) to be completed on all electrical equipment on an annual basis. There was also arrangements in place for the routine servicing and calibration, where needed, of medical equipment. We confirmed that the equipment at the practice was safe to use

The computers in the reception and clinical rooms had a panic button for staff to call for assistance.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The clinicians we spoke with were familiar with, and using current best practice guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Practice nurses told us they 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. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs reviewed patients' previous consultation notes as part of their assessment. They used the computer system to send a task to colleagues to look at new guidance on specific clinical areas. The practice was a teaching practice and supported trainee doctors. The GP told us this supported all staff to continually review and discuss new best practice guidelines.

The practice provided a service for all age groups. We heard that the local community provided services for people with learning disabilities, patients living in deprived areas and care homes and for people with mental health needs. We found GP's apart from having the overall competence to assess each patient they were very familiar with the needs of each patient; the impact of the socio-econmic environment and had particular interest areas. For example one of the GP's had developed additional competencies around working with patients who had mental health needs and patients who lacked the capacity to make decisions.

Staff providing gynaecology and family planning services received regular updates. They, in line with the expectations of the Royal College of General Practitioners guidelines, were assessed in their delivery of these services as well as other general practice expectations. Health care assistants had completed accredited training around checking patient's physical health such as blood pressure and to take blood samples.

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to and for children and young people Gillick assessments were completed. One of the GPs was the practice lead for the Mental Capacity Act 2005 and they routinely worked with service in the area to complete capacity assessments and make 'best interest' decisions.

We saw that the staff had developed an extremely effective way of monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example the annual health checks and three yearly smears.

Management, monitoring and improving outcomes for people

The practice had key personnel in organisational roles to support staff in the monitoring and improvement of outcomes for patients. These included a Data Manager and Medicines Manager who collated information to support the practice to carry out clinical audits. Examples of clinical audits included, audits to confirm that doctors in the surgery undertake minor surgical procedures were doing so in line with their registration and NICE guidance. The team was making use of clinical audits 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 upon the outcomes being achieved and areas where this could be improved.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of Quality and Outcomes framework (QOF) performance. For example we saw an audit regarding the prescribing of analgesics. Following the audit the GPs carried out medication reviews for patients who were prescribed these products and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was

Are services effective?

(for example, treatment is effective)

used to monitor the quality of services provided**.** The QOF report from 2012-2013 showed the practice was supporting patients well with conditions such as, asthma, diabetes and heart failure. QOF information for 2013-2014 indicated the practice had maintained this level of achievement and had improved their monitoring systems in other areas such as the diagnosis of dementia. GPs told us this reflected their commitment to maintaining and improving outcomes for patients.

The medicine management 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 the latest prescribing guidance was being used. The medicine management staff were using this information to support practice staff to coordinate how they scheduled the regular reviews and health checks such as for people diabetes, routine health checks and to review GP prescribing patterns. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had clearly reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had a good oversight and understanding of best treatment for each patient's needs.

Effective Staffing, equipment and facilities

From our review of information about staff training, the induction programme covered a wide range of topics such as dignity and privacy, equality and diversity as well as mandatory training. The management team had clear expectations around refresher training and this was completed in line with national expectations as well as those of the local CCG. The management team ensured that the clinicians had access to a variety of training resources. The practice manager had purchased an e-learning training resource and this meant all staff could readily update both mandatory and non-mandatory training. We saw that the mandatory training for all staff included fire awareness, information governance, managing sharps boxes, handling samples, and equality and diversity. Staff also had access to additional training related to their role. For example reception staff told us they had received conflict resolution and customer care training. We confirmed that staff had the knowledge and skills required to carry out their roles.

The staff files we reviewed showed that staff of all disciplines received annual appraisal and the clinicians had access to regular clinical supervision sessions. The administrative staff told us they were well-supported and regularly had conversations about their performance with their line manager. The practice had procedures in place to support staff in carrying out their work. For example, newly employed staff were supported in the first few weeks of working in the practice. An induction programme included time to read the practice's policies and procedures and meetings with the manager to help confirm they were able to carry out the role. Staff, including trainee doctors, told us they had easy access to a range of policies and procedures on their computers to support them in their work.

The practice manager kept a record of all training carried out by clinical and administration staff to ensure staff had the right skills to carry out their work. The practice had a rolling programme of half day training for staff, on one afternoon each month. GPs had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. The healthcare assistant told us they had supervision meetings within the nursing team to support them in their work.

The GPs received both internal appraisal and an external professional appraisal. They, as well as the nursing staff also routinely accessed clinical supervision. The appraisals involved a 360 degree process, which asks staff to complete a personal reflection on their skills and behaviour. Internal colleagues were also asked to provide open and honest feedback about the appraisee's interpersonal skills and clinical competence.

The practice manager and GP partners had ensured that all of the clinical equipment used in the practice was regularly calibrated and that relevant staff were competent to use it.

Working with other services

The practice worked with other agencies and professionals to support continuity of care for patients. The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GPs on the same day. Information was scanned onto electronic patient records in a timely manner.

Are services effective?

(for example, treatment is effective)

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.

We were told that the practice staff had formed strong links with the community nursing services. On the day of the visit we spoke with one of the community nurses. They told us they regularly met with the clinicians to discuss complex patients. They told us the GPs were easily accessible to discuss patients and there was good communication with the practice. For example, they shared clinical information through the EMIS computer system which they told us supported them to provide good care to patients.

We heard that good links had also been established with local hospital consultants and this aided the flow of information to them in respect of assisting patients to come to terms with their diagnosis and treatment. We found that the GPs made contact with secondary care services at the time they identified this need and the GP did this whilst the patient was sitting with them in the consultation room.

Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

QOF information showed the practice performed well regarding health promotion and ill health prevention initiatives. For example, in providing flu vaccinations/ smoking cessation advice, assessing for depression and providing physical health checks for patients with severe mental health conditions. The practice supported patients requesting travel vaccinations by offering patients an initial telephone consultation with the nurse. This meant the necessary vaccines were in stock when patients attended the surgery.

The practice also provided patients with information about other health and social care services such as carers' support. We saw a range of information posters and leaflets in the practice and on the practice website. Staff we spoke with were knowledgeable about other services and how to access them.

Staff at the practice were currently completing work to identify people on their patient list who also provided a carer's role. We saw that health promotion information was on display in the areas patients used and leaflets explaining different conditions were also freely available. This meant that preventative work could be completed with all these groups to assist them to find ways to improve their health and wellbeing.

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 used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nursing staff.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The service had a patient dignity policy in place. Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was a room available if patients wished to discuss something with them away from the reception area. Staff used a facility to block out other patients' names when booking appointments for patients at the reception desk. This maintained patient confidentiality.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. The consultation room doors were routinely locked when patients were being seen, which meant patient dignity was maintained. We observed staff were discreet and respectful to patients.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was in the waiting area to help ensure patients were aware of this facility. Staff we spoke with were knowledgeable about the role of the chaperone and had received training to carry out this work. Patients we spoke with told us about the process for using chaperones and felt confident that this was effective, as it was always used with them when needed. Patients also told us that they felt the staff and doctors effectively maintained their privacy and dignity.

The provider had a designated room for staff taking calls for appointments and this ensured patient information could not be overheard. We observed that when phoning in, patients would be asked for brief reasons as to why they needed an appointment. We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Calls were taken in a sound proof room at the back of the reception desk and the triage nurse worked in a self-contained room. We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit.

We looked at five CQC comment cards that patients had completed prior to the inspection and spoke with 18 patients on the day of the inspection. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and felt clinicians were extremely empathetic and compassionate.

The most recent practice patient survey showed that 86% of patients who responded said reception staff were exceptional or good. The Reception Manager told us all reception staff had recently completed a formal qualification in customer care to help them in their work. The practice had a clear set of values about patients being treated courteously and with confidentiality. This was reflected in the practice charter on their website.

Involvement in decisions and consent

The patients also told us they were happy to see any GP and the nurses as they felt all were competent and knowledgeable. Most patients found that they had been able to see their preferred GP at every appointment and two patients told us that this had been the case for well over five years. The rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hour's service.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. GPs and nursing staff told us relatives, carers or an advocate were involved helping patients who required support with making decisions. One GP we spoke with told us they were section 12 approved so regularly involved in assessing patient's capacity to make decisions, Deprivation of Liberty Safeguard (DoLS) authorisations and working with mental health practitioners determining if a patient should be detained under the mental. They were working closely with a local care home and local authority to make a decision in the patients' best interests at this service.

We saw that healthcare professionals adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's legal guardian.

Are services caring?

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. Patients' verbal consent was recorded on their patient record for routine examinations. Written consent was obtained for joint injections and gynaecological examinations. The patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted. The national GP patient survey (July 2014) found that 87% of patients said they were fully involved in making decisions.

The practice had an 'access to records' consent policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information was available for patients on the practice website and in leaflets.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their vaccinations.

Staff we spoke with were knowledgeable about how to support patients who were homeless. The staff told us they made sure the patient received urgent and necessary care whatever their housing status. They were also aware of the GP practice in the Clinical Commissioning Group (CCG) that took the lead for managing homeless patients' long term care. They told us they would ensure patients knew how to access this service.

The practice provided good disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. Staff were aware that the front doors were heavy and difficult to open. There was a buzzer at the front door for patients to press if they needed help. The practice had a wheelchair for patients who required assistance. Staff confirmed they would check the signage at the front doors to ensure patients were aware of these facilities.

There were comfortable waiting areas for patients attending an appointment and limited car parking was available nearby. There were disabled toilet facilities.

The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter for patients with a hearing impairment. Staff were knowledgeable about interpreter services for patients where English was their second language. Patients' electronic records contained alerts for staff regarding, for example patients requiring additional assistance in order to ensure the length of the appointment was appropriate. There was guidance about using interpreter services and the contact details available for staff to use. The reception staff told us that they were familiar with which patients needed this type of support and when these patients booked an appointment they made sure an interpreter was available.

Access to the service

The GPs and the clinicians had proactively reviewed the appointment booking system. The national GP survey results published in December 2013 they were found to be similar to what was expected nationally. Areas that indicated a poorer response rate related to access to timely appointments and variation in the ability of nurses and GPs. As a result last year they had introduced a process whereby the patient could make online bookings and telephone consultations with the GPs at afternoon surgery. The national GP survey results published in July 2014 showed that 83% of patients said it was easy to get through to the practice to make an appointment, 80% of respondents were satisfied with opening times and 83% patients found it easy to see a clinician, which is a significant improvement.

For over five years a triage nurse had been employed and they provided telephone advice and supported patients to determine next steps such as a face-to-face appointment with the GP or nurse or telephone consultation that day; whether the appointment could wait to the following day or if more immediate action was needed. The triage nurse told us this system had led to patients being more readily able to see a GP when this was advisable. Patients confirmed that they found this service to be a very effective mechanism for addressing their concerns and ensuring they received the most appropriate treatment. All of the patients we spoke with thought the changes to the appointments system had been positive and improved accessibility to the GPs and clinicians.

We saw that the PPG and practice had frequently completed patient surveys and comments from these showed that patients were extremely pleased with the service. Thus patients who respond to them we heard all positively commented about the availability of telephone consultations with the GP and how easy it was to get checked by clinicians.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns & Complaints

The practice has a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We saw that there was a robust complaints procedure in place and on display throughout the practice. The patients we spoke with were all aware of the process to follow should they wish to make a complaint. Patients told us that they had never needed to complain about the service. They felt the staff were constantly looking at how to improve what they did and within this process, had meticulously looked at the service from the point of view of the patient.

From a review of the complaints records, covering the last year, we saw few were made and the practice manager had thoroughly investigated all of the complaints. We saw that these investigations were extremely thorough and impartial. This meant patients could expect a full investigation of their complaint. We saw that a process was in place to analyse each complaint to see if themes were emerging or to look at trends in complaint rates or topics. In response to themes from complaints the team had reviewed and altered the appointment system in order to make it easier for patients to pre-book appointments.

Are services well-led?

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

Our findings

Leadership & Culture

All the discussions and evidence we reviewed confirmed that the management team had a clear vision and purpose. The GPs we spoke with demonstrated a deep understanding of their area of responsibility and each one clearly took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice had a clear vision and set of values which were understood by staff and evident on the practice website. The practice's mission statement included a commitment to involving patients in their own healthcare and when developing services.

There was a schedule of regular weekly, monthly and quarterly meetings within the Practice. Staff told us this helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback to the Group Manager. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

The team worked collaboratively and used their evaluations of the effectiveness of the service to not only shape the practice but to assist other health care services to recognise where changes were needed. From our discussions and review of the evidence we confirmed that this had led to the practice being consulted by local healthcare services about developments in the delivery of care in the local area.

We saw evidence that demonstrated the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people. GPs attended prescribing, medicines management and safeguarding meetings and shared information within the practice.

Governance Arrangements

We found that the practice had systems for monitoring all aspects of the service and these were used to plan future developments and to make improvements to the service. The practice managers and GPs led on the individual aspects of governance such as complaints, risk management and audits within the practice. The systems in place ensured strong governance arrangements were in place.

The GP partners took an active leadership role for overseeing that the systems in place were consistently being used and were effective. For example there were processes in place to frequently review patient and staff satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. There was evidence of forward planning within the practice around the need to review and update policies and check the accuracy of current risk management tools.

The practice regularly submitted governance and performance data to the CCG.

Systems to monitor and improve quality & improvement (leadership)

The practice used information they collected for the Quality and Outcomes framework (QOF) and national programmes such as vaccination and screening to monitor patient quality outcomes. GPs told us they worked with the Medicines Manager and pharmacist from the CCG in identifying which clinical audits to carry out. Clinical audits were also carried out following significant events and complaints. These were discussed within the practice through a schedule of meetings with staff groups.

Staff told us they had annual appraisals which included looking at their performance and development needs. The practice was developing a competency framework for health care assistants using guidance from the Royal College of Nursing. This meant that staff were supported to have the right skills and knowledge to provide high quality care.

The GPs and practice manager all contributed to risk management, clinical audits, staff training and significant event analysis. It was evident that quality monitoring was taking place and action taken to improve quality.

The practice worked with the CCG to share information and implement new methods of working. For example the practice was implementing the 'named GP' initiative for patients over 75 to support continuity of care. The practice was proactive in seeking new ways of improving services for

Are services well-led?

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

patients. For example we saw bids in place to the innovation fund to develop 'Skype' (on-line) consultations, increase interagency working by appointing a patient champion and for resources to improve patient feedback.

The practice is a teaching facility so is subject to regular review by the local deanery to ensure they remain fit to train GPs and medical students.

Patient Experience & Involvement

We received five completed patient comment card and spoke with 12 people on the day of our visit. We spoke with people from different age groups, including parents and children, patients with different physical health care needs and those who had various levels of contact with the practice. All these patients were very complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They all felt the doctors and nurses were extremely competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

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

The practice had an active patient participation group (PPG) who had been operating at the practice for over five years. We met one of the members of this group and they discussed how the practice valued their contribution to the operation of the service and listened to their insights into the patient experience. We saw examples of the surveys they conducted and how the findings had been used by the practice to improve the services. For example the introduction of telephone consultations eighteen months previously had been in response to patients' feedback about how to improve the appointment system. The PPG member also discussed with us the work the practice was currently doing to widen the age group of PPG members. To increase participation from people from different ethnic backgrounds and younger patients the practice and PPG had offered the option of email and online discussions. Staff welcomed the contribution the PPG made to improve the service.

From a review of the minutes of their meetings we found the PPG were very effective and engaged. Their views were listened to and used to improve the service being offered at the practice. We were shown evidence to confirm that the group regularly made suggestions about how to improve the service and these were implemented and then evaluated to see if they made a difference to the service. For example the PPG suggested the introduction of an IPad so patients could book in and find out which waiting room they needed to go to without needing to wait for the receptionist to finish conversations with other patients.

Information about the PPG was available on the practice website and in the practice newsletter. Patients were able to sign up on line or complete a form and hand it in to reception staff. Patients were encouraged to send the PPG or the Group Manager their comments, suggestions and questions via the practice website.

Management lead through learning & improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. They had the opportunity to feedback on how useful the induction period had been and to make suggestions on ways to improve it. They met with the practice manager to discuss progress and ensure they had the right skills to do their job. Ongoing peer support and formal appraisals were evident which included identifying learning and development needs.

Staff told us they had good access to training and the practice manager monitored staff training to ensure essential training was completed each year. We saw that a comprehensive training matrix for all staff employed in the organisation was in place. The practice had half a day protected learning time each month for training and sharing information.

The GPs and clinical staff held regular clinical meetings where they discussed changes to practice. The practice also scheduled meetings for the whole staff team, clinical, non-clinical and operations management. Staff were encouraged to attend various staff meetings and we saw from the minutes of clinicians meetings that they discussed improvements that could be made to the service. Our discussions confirmed that the whole team were highly focused and very open to exploring how they could improve. We confirmed that this had led to constant cycle of improvement and the practices desire to constantly strive for excellence.

Identification & Management of Risk

The practice had systems to identify, assess and manage risks related to the service. We saw the practice's health

Are services well-led?

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

and safety policy which included clear guidance for staff. Monthly health and safety meetings were being introduced and we saw evidence of staff involvement and cascading information.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training. All of the systems we reviewed showed that the practice was effectively monitored by the practice manager and senior staff.

The practice carried out audits and checks to monitor the quality of services provided. For example the GPs used prescribing information provided by the CCG pharmacist and national alerts to review the medication they prescribed. This helped to ensure patients were receiving the most appropriate medication in line with best practice.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Care was tailored to individual needs and circumstances, including a person's expectations, values and choices. Consideration of carer's needs, particularly where elderly carer

Regular 'patient care reviews', involving patients and carers were completed. A named GP was accountable for the care of each patient over the age of 75 years.

Clinicians ensured patients and carers received appropriate coordinated, multi-disciplinary (including for those people who move into a care home, or those returning home after hospital admission)

Unplanned admissions and readmissions for this group regularly reviewed and action was taken to make any necessary improvements.

Staff had the knowledge, skills and competence to respond to the needs of this population group. Including training in appropriate communication skills

Access to services, including flexible appointment times and same day telephone consultations where appropriate.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

Care was tailored to individual needs and circumstances, including a person's expectations, values and choices. Consideration of carer's needs.

Regular 'patient care reviews', involving patients and carers were completed.

Staff had the knowledge, skills and competence to respond to the needs of this population group

Clinicians supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their overall care. GPs acted as a coordinator and navigator of care where this was appropriate.

Clinicians made referrals to specialists in an appropriate and timely way.

The practice proactively monitored the prevalence of long-term conditions within the practice population including action to respond to a sudden deterioration of a condition; to identify patients with a long-term condition and those at risk of developing one.

A range of health promotion advice and information related to various conditions including advice on self-management were on display in the practice.

Clinicians proactively case managed and completed long-term monitoring of these patients' needs.

Access to services, including flexible appointment times and same day telephone consultations where appropriate.

Staff received appropriate training to ensure they have the expertise and knowledge to work with patients. People are signposted to patient groups and supported to access a support network.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice safeguarded children, including ensuring there was access early identification of need and help offered with other services early.

The practice prioritised the needs of children, young people and families living in disadvantaged circumstances, looked after children, children of substance abusing parents, young carers. Extra support offered to these families

Staff had the knowledge, skills and competences to recognise and respond to an acutely ill child.

Clinicians completed regular assessment of children's development and early identification of problems in the physical and mental wellbeing of children and young people and when necessary followed up of issues.

The practice provided primary and pre-school immunisation, health promotion advice

Children and young people treated in an age appropriate way and are recognised as an individual, with their preferences considered.

Communication, information sharing and decision making with other agencies, particularly midwives, health visitors and school nurses was well-established.

Generalist medical care was provided to patients during their pregnancy

Clinicians provided information, including on lifestyle advice on healthy living, given to pre-expectant mothers, expectant mothers and fathers to patients.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

Appointments system enables access for this group and practice easy to contact

Staff proactively looked at how they could learn from any incidents and they used the latest guidance to improve the service.

Care and treatment was being considered in line with current published best practice for this patient group. These patients' needs were consistently met. Referrals to secondary care were made as soon as the need was identified.

The practice had a clear complaints policy and responded appropriately to complaints about the service. Regular patient surveys were conducted, which covered their satisfaction with the service and the provider took action to make suggested improvements.

Governance and risk management structures were in place. The leadership team had a clear vision about how to deliver the best care for older patients.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

One of the practice nurses led on ensuring people with learning disabilities were given equitable access to the GP services.

Open access to the service was provided, which meant all people from the catchment area could register with the practice, including those with no fixed abode

The practice provided sign-posting to specialist support groups.

The practice proactively assessed and monitored the practice population needs, including for people in vulnerable circumstances.

The practice had a structured approach to addressing health needs and inequalities

People were encouraged to participate in health promotion activities, such as breast screening, cytology, smoking cessation.

Patients told us they felt able to trust the practice staff with personal information.

Staff took time to listen to people from these groups.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice proactively assessed and monitored the practice population needs, including for

patients with mental health needs, including within hard to reach groups.

Staff had the skills, competences and knowledge to:

- Assess and respond to risk for patients experiencing mental illness (including suicide prevention)
- Support people to access emergency care and treatment when experiencing a mental health crisis
- Recognise and manage referrals of more complex mental health problems to the appropriate specialist services

Care was tailored to their individual needs and circumstances, including their physical health needs. Including annual health checks for people with serious mental illnesses

The practice proactively offered access to a variety of treatments such as listening and advice, and counselling services.