Dr R Salmon & Partners

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr R Salmon & Partners on 6 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, families, children and young people, working age people (including those recently retired), people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Practice staff were kind and caring and treated patients with dignity and respect.
- The practice was safe for both patients and staff. Robust procedures helped to identify risks and where improvements could be made
- The clinical staff at the practice provided effective consultations, care and treatment in line with recommended guidance.
- Services provided met the needs of all population groups.
- The practice had strong visible leadership and staff were involved in the vision of providing high quality healthcare.
- 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 for.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff had received safeguarding training and understood the reporting procedures. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Medicines were stored correctly and monitored for expiry dates.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients were satisfied with the way they were treated by the GPs, nurses and other staff. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Carers were identified and support offered to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They were aware of their practice population and tailored their services accordingly. Patients were generally satisfied with the appointment system and the availability of the GPs and the nurse. Patients had a choice of GP if they wanted one. Telephone consultations and home visits were available when necessary. The premises were suitable for patients who were disabled or with limited mobility. A prescription service was available for those patients unable to attend the

Summary of findings

practice and a local pharmacy made home deliveries. There was an effective complaints system in place that was fit for purpose, we saw that complaints received had been dealt with in line with the NHS complaints procedures, were reviewed and any learning needs identified and shared with the whole practice team.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy for the delivery of high quality care and staff were working towards achieving it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular team meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events. An ethos of learning and improvement was present amongst all staff.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the population group of older people. Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. The practice provided medical cover as hospital practitioners to a local twenty bed rehabilitation and admissions avoidance unit and provided twice yearly on site ward rounds at a local nursing home to review patients medications and complete health checks. Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for the coordination of their care. The practice held bi-weekly multi disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible midwives, health visitors and community psychiatric nurses to discuss older and vulnerable patients. In addition the MDT coordinator organised monthly meetings of GPs, district nurses, palliative care nurses and administrative staff to discuss older patients and review future care needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority to review any additional support they may need. 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. The practice held bi-weekly multi disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible midwives, health visitors and community psychiatric nurses to discuss vulnerable patients. In addition the MDT coordinator organised monthly meetings of doctors, district nurses, palliative care nurses and administrative staff to discuss patients with long term conditions and review future care needs.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-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 high for all standard childhood immunisations. We saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. The practice oversaw the care and respite of end of life patients at a local children's hospice. Antenatal care was referred in a timely way to external healthcare professionals. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. The practice held bi-weekly multi disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible midwives, health visitors and community psychiatric nurses to discuss vulnerable patients. In addition the MDT coordinator organised monthly meetings of doctors, district nurses, palliative care nurses and administrative staff to discuss complex patients and review future care needs.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The appointment system met their needs. Appointments could be booked on-line. Health promotion advice was readily available including smoking cessation, healthy eating and alcohol consumption The practice provided vaccination advice and health and sexual health advice to students at the University and attended fresher's week functions to promote the health services available for students at the campus branch.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Double appointment times were offered to patients who were vulnerable or with learning disabilities. All patients were able to register at the practice as temporary residents, regardless of their personal circumstances, including the homeless and members of the travelling community. Carers of those living in vulnerable circumstances were identified and offered support which included signposting them to external agencies. Staff knew how to recognise

signs of abuse in vulnerable adults and children. A lead for safeguarding monitored those patients known to be at risk of abuse. All staff had been trained in safeguarding and were very aware of the different types of abuse that could occur and their responsibilities in reporting it. The practice held bi-weekly multi disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible midwives, health visitors and community psychiatric nurses to discuss vulnerable patients. In addition the MDT coordinator organised monthly meetings of GPs, district nurses, palliative care nurses and administrative staff to discuss vulnerable patients and review future care needs.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health. The practice was aware of the number of patients they had registered who were suffering from dementia and they were offered additional support. This included those with caring responsibilities. A register of patients with dementia was maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and then on-going monitoring of their condition took place after discharge back to the GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations such as the mental health charity MIND and the community psychiatric nurse that provided counselling and support. Two GPs serve as mental health leads for the local CCG. The practice held bi-weekly multi disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible midwives, health visitors and community psychiatric nurses to discuss vulnerable patients. In addition the MDT coordinator organised monthly meetings of doctors, district nurses, palliative care nurses and administrative staff to discuss patients with poor mental health and review future care needs.

Summary of findings

What people who use the service say

The practice provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected three comment cards; all the cards indicated that patients were satisfied with the support, care and treatment they received from the practice. Comments cards also included positive comments about the skills of the staff, the treatment provided by the GPs and nurses, the cleanliness of the practice, the support and helpfulness of the staff and the way staff listened to their needs. Patients recorded they were satisfied with the care and treatment they received. These findings were also reflected during our conversations with patients during and after our inspection.

The patients we spoke with told us they felt their treatment was professional and effective and they were happy with the service provided. They told us things were clearly explained to them and clinicians gave them sufficient time during consultations and information to be able to make decisions about their treatment and care without feeling pressured. Patients told us that the team were supportive and that they thought the practice was well run. Patients told us if they needed to complain they would speak to the reception team or the management team. We did see that one patient had cause to complain as they were unhappy about their care, but most patients we spoke with felt their concerns would be listened to.

Patients told us they were happy with the supply of repeat prescriptions.

Dr R Salmon & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP specialist advisor and practice manager specialist advisor and two CQC inspectors.

Background to Dr R Salmon & Partners

The Red House Surgery provides primary medical services to approximately 18,000 patients and is situated in central Cambridge, Cambridgeshire. The practice provides medical services to Anglia Ruskin University and works from a purpose-built facility on campus. Some 5,500 patients are registered there.

The practice has a team of nine GPs meeting patients' needs. Four GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there is one nurse prescriber, one emergency nurse practitioner, two health care assistants and a phlebotomist. The practice manager was supported by a team of medical secretaries, reception and administration staff. The Red House surgery is a training practice and a GP registrar provided clinics throughout the year. Medical students also attended the practice for training.

Patients using the practice had access to a range of other services and visiting healthcare professionals. These included health visitors, midwives and Improving Access to Psychological Services (IAPT).

The building provides easy access with accessible toilets. A limited number of car parking facilities are available behind the practice and bus stops are available nearby.

Outside of practice opening hours a service is provided by another health care provider, by patients dialling the national 111 service. Details of how to access emergency and non-emergency treatment and advice were available within the practice and on its website.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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

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

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 inspecting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 9 April 2015. During our inspection we spoke with a range of staff including GP partners, practice nurses, health care assistants, reception and administrative staff and the practice management team. We spoke with patients who used the service and visiting health care professionals. We observed how people were being cared for and talked with carers and family members and reviewed personal care or treatment records of patients. We reviewed three comment cards where patients and members of the public shared their views and experiences of the service.

We looked at records and documents in relation to staff training and recruitment. We conducted a tour of the premises and looked at records in relation to the safe maintenance of premises, facilities and equipment.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. A computerised reporting system was in place which staff were encouraged to use. Notifications of such incidents were automatically sent to the practice manager to review and action.

We reviewed significant events and complaints for the last two years and found that they had been investigated, analysed and learning identified. Action had been taken to reduce the risk of reoccurrence. Staff spoken with were aware of safety incidents that had occurred and confirmed that these had been discussed with them at regular team meetings. Minutes of meetings we looked at confirmed this. The practice was able to assure us that safety issues had been managed consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There had been eight significant events in the last six months and we reviewed a sample of these. We found that they had been recorded, analysed, investigated and actions implemented where necessary.

Significant events and complaints and the learning from them was discussed at monthly staff meetings and monitored for common themes and trends. We looked at minutes of staff meetings where these had been discussed and recorded, we found that staff spoken with were aware of the incidents that had occurred and understood the learning from them.

A staff meeting was held monthly and all staff required to attend. This included the GPs and the nursing staff. Management meetings were also held where significant events and complaints were discussed so that there was oversight of any issues that had occurred. There was evidence that the practice had learned from these. Staff, including receptionists, secretaries, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet. These forms were then automatically sent to the practice manager. We saw systems used to manage and monitor these incidents. We tracked eight incidents and saw records were completed in a comprehensive and timely manner. We found that there was an effective system of monitoring reported incidents and that safety issues were prioritised. There was also clinical oversight of such incidents. For example following an incident of power loss to a vaccine storage fridge and error in the prescribing of high risk medication. 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.

National patient safety alerts were analysed and actioned by the duty GP who disseminated them to relevant staff. The GPs we spoke with confirmed the system in place and displayed knowledge of alerts that had been received and relevant to their area of responsibility.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff at the practice, including administrative staff, undertook training in safeguarding vulnerable adults and children. Staff spoke knowledgably about safeguarding issues and told us they felt confident in reporting them if necessary. One of the partners was the lead in the practice for safeguarding patients. We viewed contact details of agencies involved in protecting people were widely available around the practice making them easily accessible to both staff and patients.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of

normal hours. For example staff told us how they would initiate a contact with the relevant agencies should they have a concern and notify the duty GP and the safeguarding GP lead.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead GP was 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 or patients with a diagnosis of dementia or those requiring additional support from a carer. There were systems in place to follow up children who persistently failed to attend appointments. For example for childhood immunisations. One GP described how the practice encouraged attendance and education for childhood immunisation in particular for those patients and families from the local travelling communities.

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). All nursing staff, including health care assistants, had been trained to be a chaperone. There were designated reception staff who would act as a chaperone if nursing staff were not available. Staff who undertook chaperoning had received training and spoke knowledgeably about the correct way this should be undertaken. This included where to stand to be able to observe the examination.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine fridges and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. Staff were not aware of any written policy for actions to take in the event of a potential failure. However they were able to clearly describe the actions they took when a recent power failure to a vaccine fridge occurred. The practice staff followed the cold chain policy when medicines arrived so that they were placed in a fridge as soon as possible.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. This included the medicines available in the event of an emergency at the practice, the GPs emergency bag used when conducting home visits with patients and stocks of vaccinations used by the nurses at the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. This included checking whether a medicines review was due before giving it to the patient. A system was in place on the computerised patient record system to identify patients who were due for a review and this was being actioned. There were systems in place for reviewing repeat medications for patients with co-morbidities/multiple medications.

The practice had made arrangements with local pharmacies so that patients could collect their dispensed prescriptions at local pharmacy and to order repeat medicines from the practice via the pharmacy or by email request. Information about this was available to patients at reception, in the practice leaflet and on their website.

Cleanliness and infection control

The practice had a lead for infection control who had received appropriate training. An infection control policy had been read by all staff working at the practice and they had signed to show that this had been undertaken and the policy understood.

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 cleaning contractor had been appointed to undertake the cleaning of the practice. 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. We saw that 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.

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 observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Equipment

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

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and blood glucose testing equipment for patients with diabetes.

We found that when staff reported shortages or problems with equipment this was actioned by the practice manager and supported by the GPs. For example two of the nursing team described the problems with fittings and equipment in two of the treatment room. The practice manager told us as a result it had been agreed that new fixtures and fittings would be installed in these rooms.

Staffing and recruitment

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

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Good

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, we saw that risks around loss of power to a vaccine fridge had been assessed and mitigating actions had been put in place.

Other systems were in place to monitor risk including medicine reviews for patients, handling national patient safety alerts, dealing with emergencies and the servicing, maintenance and calibration of medical equipment. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff were able to give examples of the actions they would take for patients waiting in the reception area whose health rapidly deteriorated.

Patients with conditions which made them more vulnerable were identified and monitored through the use of registers and a multidisciplinary approach with other healthcare professionals. This provided a systematic, organised approach to identify patients at risk of deteriorating rapidly so that care plans could be put in place to support them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient at the branch surgery and that the practice had learned from this appropriately.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. These included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to and external organisations that would be able to provide the necessary support required to maintain some level of service for their patients.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training including the use of fire extinguishers and that they practised regular fire drills. Staff told us they had received recent training in fire safety which had increased their confidence in operating and handling the different fire extinguishers available in the practice. Fire extinguishers we viewed had all been serviced within the last year to ensure their effective operation if needed. All treatment rooms had a panic button so that clinicians could summon assistance in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP(s) told us they led on all specialist clinical areas such as diabetes, mental health and had a specialist interest in psychiatric care. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Our review of the multidisciplinary team meetings and clinical meeting minutes confirmed that this happened. The GP(s) told us they attended 'time to learn' a training resource provided by the Clinical Commissioning Group (CCG).

We saw the practice had a clear system in place to manage referrals in a timely and effective manner. The practice addressed prescribing practices by individual GPs and they were continuing to actively monitor their performance through further audit cycles. The practice compared their referral rates with comparable practices within their CCG and Local Commissioning Group (LCG). The practice had a robust system in place to monitor delays with referrals or rejections for those patients who had be incorrectly referred for assessment or treatment.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. Patients were assessed individually according to the risks they presented with and changes made as appropriate to their care plans. The practice had appointed a consultancy company to review electronic medical records and identify incorrect read codes; this would ensure treatment and care records were correct and optimise disease management.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, they professionally and as a practice, reflected on their performance. Staff spoke positively about the culture in the practice.

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure improved outcomes for patients. For example, we looked at an audit investigating the prescribing of first line antibiotics across GPs at the practice. The aim of the audit was to investigate the prescribing of antibiotic. Antibiotics are important medicines for treating bacterial infections. Antibiotic resistance is driven by overusing and inappropriate prescribing. The first audit demonstrated that antibiotics used as secondary line of treatment were being prescribed as a first line antibiotic treatment. Information was shared with GPs, reminding them of antibiotic formulary guidance. The practice also put processes in place to ensure

information regarding reasons for choice of antibiotics were clearly indicated in patient's records, for example where an allergy status was appropriate. The second audit reviewed 107 prescriptions for antibiotics over an eight week period; the audit was able to clearly demonstrate improvement in practice prescribing for antibiotics.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had 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 oversight and a good understanding of best treatment for each patient's needs.

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

One member of staff told us the practice was reviewing appointments for health and medication reviews to enable patients to attend for all their annual reviews at a single appointment. This was to prevent patients with multiple health care needs such as coronary heart disease, asthma or diabetes attending the service for multiple reviews. This would ensure treatment and care was monitored and would reduce the need for patients attending repeated appointments at the service.

Effective staffing

Practice staffing included medical, nursing, managerial, administrative and secretarial staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among a loyal administrative and clinical team, with some staff having been employed by the practice for eleven years.

The GP(s) were up to date with their yearly continuing professional development requirements and were to be revalidated in March 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented and planned for. Our interviews with staff confirmed that the practice was proactive in providing support for training. Staff described the time restraints they had previously experienced for training and review of practice policies. We saw that changes to staff rotas had provided protected time for staff e-learning and policy reviews.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. This included the administration of vaccines, cervical cytology and managing and supporting patients with long term conditions such as diabetes. Staff were able to demonstrate that they had appropriate training to fulfil these roles.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. The GPs told us they informally debriefed all medical students and GP registrars who trained at the practice before they left to identify ways in which teaching and training at the practice could be improved. We were told areas for improvement that the trainees suggested were reviewed and where actioned.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

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 from communications with other care providers on the day they were received. All GPs reviewed all communications received by the practice and GPs peer reviewed all referral letters from the practice to secondary care. The named GP

Good

Are services effective?

(for example, treatment is effective)

who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook an annual audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed. We also saw how the practice spoke with and worked collaboratively with other hospitals and consultants to the benefit of its patients. The practice provided medical cover as hospital practitioners to a local twenty bed rehabilitation and admissions avoidance unit and provided twice yearly on site ward rounds at a local nursing home to review patients medications and health checks. One GP told us the community geriatrician and a representative from the local CCG medicines management team joined the practice team at these visits to provide expertise and advise on effective treatment and prescribing. The practice also oversaw the care and of respite of end of life patients at a local children's hospice.

The practice held daily morning clinical breaks which allowed for informal opportunities to discuss care and treatment and seek advice from colleagues. One GP told us the skills they acquired in other roles, such as at the hospital and children's hospice had proved advantageous to other older patients and families with young children. Areas such as palliative care, treatment of patients with dementia and vulnerable adults and children had provided the GPs with experience in assessing capacity and caring for people with cognitive impairment.

There were regular meetings, involving other different professionals, to discuss specific patients' needs. For example patients with end of life care needs, and children at risk. The practice held bi-weekly multidisciplinary team (MDT) meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by GPs, district nurses, practice nurses, and when possible midwives, health visitors and community psychiatric nurses to discuss vulnerable patients and make decisions about care planning which were documented in a shared care record. In addition the practice liaised with the locality MDT coordinator who organised monthly local meetings of GPs, district nurses, palliative care nurses and administrative staff. We saw minutes of meetings where teams had discussed future care requirements for patients with complex needs. Staff we spoke with told us this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice website provided patients with information about the arrangements to share information about them and how to opt out of any information sharing arrangements.

Electronic systems were also in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

Two GPs were accredited trainers by the East of England Deanery, with one GP acting chair of the Cambridge GP trainers group. The practice had one full time GP trainee and provided training for students from all stages of the Cambridge University undergraduate scheme. In addition the practice acted as examiners for students' final exams. Two GPs were mental health leads for the local CCG.

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. Electronic systems were also in place for making referrals, and the practice made 85% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The GPs told us these were amongst the best in the region and were attributable in part to the GPs good habits and the work of the secretarial team. The practice's medical secretary operated an effective tracking system to identify any urgent referrals and to ensure that all referrals were followed up. Staff reported that this system was easy to use. All GP referral letters were peer reviewed by the other GPs within the

practice. This was to ensure standards of quality were maintained, where necessary improve performance by offering suggestions and advice and provide credibility to ensure referrals were necessary.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice secretary showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has 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).

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

Consent to care and treatment

A consent policy was in place that identified the different types of consent that could be obtained including implied, verbal and written. We found that clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The GPs we spoke with were clear about mental capacity in relation to the assessment of a patient's ability to consent to receiving care and treatment. This included patients with a learning disability or dementia where a judgement was required to be made on their mental capacity to consent and whether a decision was required to be made in their best interests. We were satisfied that correct procedures were being followed.

Nursing staff were aware of the need to consider whether a person attending with a child had the legal right to agree to consent to treatment on their behalf. This included where child immunisations were due and a child attended with a person that might not be legally entitled to consent to treatment on their behalf, such as a step-relative or grandparent.

The practice also followed the correct procedures when considering making do not attempt resuscitation orders. This involved support for patients to make their own decisions and how these should be documented in the medical notes.

Clinical and reception staff we spoke with were aware of the consent issues known as Gillick competence. They told us that if a child under the age of 16 attended for an appointment with a GP or nurse without a parent or guardian and they indicated that they did not want one present, they would be given an appointment. The GPs we spoke with were aware that they then had to apply the Gillick competency test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

All staff we spoke with were familiar with the importance of patient consent. We saw evidence of the learning in place within the practice following a complaint relating to consent for a childhood immunisation. The practice electronic system contained 'hot keys' to enable staff to document that patients had been asked for consent and offered a chaperone. We saw the practice had undertaken an audit of consent to analyse the practice performance in this domain and was due to undergo a second audit cycle.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice was aware of the strategic objectives of the health and social care needs of the local area and directed their services towards them. This information was used to help focus health promotion activity.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice achieved between a minimum of 65% to a maximum of 89.1% for the previous years childhood immunisation uptake. We were told the practice struggled to reach 90% childhood immunisation rates with difficulty, due in part to having a high number of travelling families, who even with specific targeting, did not comply with the immunisation schedule. One GP told us those who moved outside of the target groups and were not up to date at that time were currently not followed up by the practice. We were told the practice planned to devise an approach to work collaboratively with local health visitors to increase uptake through education, and address and identify the fears that these vulnerable families have of vaccines.

Flu and shingles vaccinations were available for elderly patients or those with conditions that made them vulnerable to the virus. Patients could also attend the practice for smoking cessation advice and smokers were identified through the patient record system and pro-actively contacted to attend the practice.

The practice made positive use of emails and text messages to communicate with patients. For example, to send appointment reminders. Reception staff were pro-active in obtaining the latest mobile numbers of their patients and sought permission to contact them about health prevention services.

We found a wealth of health information available for patients within the communal waiting areas. They included promotional material relating to vaccination programmes and general health advice regarding diet and smoking. The information was regularly reviewed to ensure the information remained current.

The practice had a register of patients in need of palliative care, suffering from dementia, those who were frail and at risk of their health deteriorating rapidly and for those with learning disabilities. Monthly multidisciplinary meetings took place where the care and treatment of individual patients was discussed. This identified the most appropriate care and treatment for them and allowed them to be treated in their own homes. Other healthcare professionals involved in this process included district nurses, social services and Macmillan nurses.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Measures had been put in place to maintain patients' privacy and prevent conversations being overheard in the waiting room. There was a large sign above the reception desk requesting that patients be mindful of the person in front of them. There was another sign advising patients that if they needed to speak in confidence, they could request to be seen in a separate room. One receptionist told us they had recently used the practice's phlebotomist's room to ensure that one young vulnerable adult and their support worker were able to complete registration forms in private.

There was one treatment room directly off the waiting room which was not fully sound proof. In response to this, a radio was played in the waiting room to prevent conversations between patients and clinicians being overheard. The practice had recently submitted a business plan to obtain funding to increase the sound proofing in this room.

In response to a patient suggestion, screens had been fitted around the booking-in touch screen to increase the confidentiality of patient information. Staff told us they always used patients' computerised records identification number in receptions areas, rather than their actual name, to protect their identity.

We spent time in the waiting room and observed a number of interactions between the reception staff and patients coming into the practice. The quality of interaction was consistently good, with staff showing genuine empathy and respect for patients, both on the phone and face to face. We noted on one occasion that the receptionist took considerable time to explain clearly and simply the practice's registration process to one patient whose first language was not English.

Curtains were provided around examination couches in the consulting rooms we saw, ensuring patients' privacy was maintained when undergoing intimate examinations or whilst dressing. We viewed notices next to examination couches reminding patients that they could request a chaperone if needed. Throughout our visit we noted that consulting and treatment room doors were kept shut to ensure patients privacy during their appointment.

Care planning and involvement in decisions about care and treatment

We spoke with the manager of a local care home who knew the practice well. They told us that the GPs actively involved residents in decisions about their care and were also good at listening to, and consulting with, their staff about the best way to manage the residents' health needs.

We reviewed the most recent results from the National GP Patient Survey (a survey that gives patients the opportunity to comment on their experience of their GP practice). Based on 110 surveys sent back, 89% of respondents reported the last nurse they saw or spoke to was good at involving them in decisions about their care. This was above the average for the area which was 86%. The results for GPs were less favourable with of 70% of respondents reporting that the last GP they saw or spoke to was good at involving them in decisions about their care. This was below the average for the area which was 83%. However, 86% reported the last GP they saw or spoke to was good at listening to them, and 82% found the last GP they saw or spoke to was good at giving them enough time.

Patients we spoke with reported that staff listened to them and talked to them appropriately. They stated that their treatment options had been discussed with them and the results of tests had been fully explained to them in a way that they understood. One patient reported that they had felt much supported by a GP who had advocated strongly on their behalf, when challenging the decision of a hospital doctor. Another told us that the practice's diabetic nurses had listened to them closely and worked hard to get their medication levels correct.

Patient/carer support to cope emotionally with care and treatment

There was a wide range of leaflets and posters in the practice's waiting room, giving patients good information about local support and advocacy groups whom they could contact for additional support. The practice took part in the Carer's Prescription Service. When GPs identified patients in their practice who provided care to others, they could write a prescription for them which could be 'cashed in' by the carer to access a specialist worker at Carers' Trust Cambridgeshire for support, information and respite care. The practice had also been awarded a 'surgery of the month' by the local CCG in recognition for its support to unpaid and informal carers. There was a dedicated notice board in the waiting area for patients with caring

Good

Are services caring?

responsibilities informing them of various avenues of support available to them. The practice's computer systems did have an alert system to identify patients with caring responsibilities; however this was not used consistently by all relevant staff.

The manager of a local care home told us the GPs were empathetic and caring to their residents, and described the end of life care given by them as 'spot on'. They told us of a recent resident's death where two of the GPs had worked very closely with staff at the home, the patient themselves and their family to ensure the patients last days were comfortable, pain free and dignified. There were regular monthly multi-disciplinary meetings attended by the local palliative care team to ensure that important patient information was shared and joined-up care planned for those at the end of their lives. When the practice was notified of a patient's death, it was recorded on a covered notice board in the reception for information and a system was in place to ensure that all relevant agencies were informed of the patient's death. The patient's regular GP would then decide if it was appropriate for the practice to send a supportive letter of condolence to their relatives.

Staff we spoke with had a good knowledge of a range of local counselling and support agencies, and regularly referred patients to them when needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice offered a branch surgery at the Anglia Ruskin University. This provided access to medical services for 5000 students and operated on a daily basis with a GP and a nurse offering appointments. This ensured that the practice could accurately respond to the psychological and medical needs of the student population.

The national GP patient survey indicated that 78.4% of registered patients who responded were satisfied with the telephone access compared with 77.6% nationally. This indicated the practice is slightly better than the national average.

There were arrangements to refer or transfer patients to another service so patients' needs were met at the right time. These could be secondary referrals to specialist clinics such as diabetes, chronic obstructive pulmonary disease (COPD) or mental health as an example. The practice had referral criteria that helped clinicians to make timely referrals after relevant investigations and tests had been performed.

We saw that the practice had an active Patient Participation Group (PPG), a group of patients registered with a practice, who work with the practice to improve services and the quality of care. We saw that feedback provided by the PPG were listened to and implemented where appropriate. For example we spoke to three members of the PPG and all stated they had positive experiences in the practice responding to their needs. One of the members of the PPG we spoke with stated they would like the dates and times agreed in advance for the meetings and felt the arrangements for arranging were very ad-hoc at present.

Tackling inequity and promoting equality

The practice was located in a converted house and consultation rooms were on the ground floor and on the first floor. Patients who had mobility difficulties were seen on the ground floor consultation rooms. The practice manager told us that most of the patients had been registered with the practice for a long time and would always ask if they needed to be seen on the ground floor consultation room. The reception staff provide a dynamic assessment of each patient's mobility and offer a ground floor consultation if the individual appears to need one.

The practice had arrangements for accessing interpreting services for patients whose first language was not English. The Practice Manager told us that most of the patients had been registered with the practice for a long time and the practice knew their patient population well.

Staff also told us some patients were hearing impaired and the practice was able to organise sign language interpreters for them. There was a hearing induction 'loop system' available for patients with hearing difficulties.

The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that was convenient to them. Patients who were unable to attend the practice could also arrange for home visits.

The practice had an electronic board in the waiting room that allowed patients to see how long they would be waiting to be seen once they arrived at the practice. We saw this appeared to be broken, showing zero as the waiting time; patients we spoke with told us this board was never used.

Access to the service

The practice was located in a converted house with a recent extension. There was a ramp to access the surgery but there were no automatic doors. If patients arrived at the surgery in a wheelchair and had difficulty gaining access up the ramp, staff told us they would assist the patient if necessary. The ramp was located at the side of the building and had an intercom at the base; staff told us that reception staff would answer this intercom and assist any patient that required help.

There were consultation rooms on the ground floor and on the first floor. Staff told us that they would book patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

who had mobility difficulties on the ground floor so that they did not have to climb the stairs. One of the GPs we spoke with told us the practice recognised the issues with accessibility and showed us the plans that the practice have submitted regarding the purchase of land and building of a bespoke facility. We were told this has received primary funding approval and the practice were waiting for the next stage in the process.

Appointments were available from 8.30am to 6pm Monday to Friday. The practice opened from 6.30 pm to 8.30 pm one evening a week and from 8.30 am to 11.30 am on Saturday mornings to enable access for working families. The practice stated that most patients were offered same day appointments whenever they were requested and the reception staff endeavoured to book the patient's own GP whenever possible. We asked patients at the surgery who confirmed this was the case. We witnessed reception staff booking same day appointments in all cases without the need for the patient to justify their request.

The practice was open for a limited number of appointments on a Saturday. These were only available to be pre-booked and not on the day. The availability of this service was displayed in the waiting area and on the website. Information for urgent care was available from the practice website and was additionally displayed inside the waiting area. We saw evidence that the GPs fully engaged with the local emergency care centre to appropriate triage patients. We saw through the use of the same day appointments, telephone consultations and the availability for home visits that patients had a range of options to access services. Patients we spoke to did not report any difficulty in making an appointment. Patients were able to sign up for electronic communication, which allowed them to receive reminders and referral appointment dates electronically.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

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 arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hours service was provided by an external provider contracted by the clinical commissioning group (CCG). Details of how to contact the out of hours provider were available on the practice website as well as in the practice.

Telephone consultations were carried out by the duty GP. The patient was able to discuss their concerns with the GP on the telephone and where necessary the GP would provide an appointment on the same or on a more appropriate day. The surgery did not offer a service where any patient group received a priority appointment but we were told every patient was offered a same day service.

We spoke to two patients who told us they did not have an issue getting an appointment and they were always able to get in the same day they needed to.

Repeat prescriptions were dealt with on the same day by a dedicated member of staff; we saw this process in place together with effective steps being taken when these were collected. The process was robust and ensured timely issuing of repeat prescriptions with adequate security on collection.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice who was the practice manager. The practice managed complaints proactively, we saw the systems in place that enabled the practice to record and monitor complaints effectively.

We saw there was a complaints leaflet that outlined the practice policy in dealing proactively with complaints, together with how to complain. The commitment of the practice to listening to patients and the principles of how they work was also contained in this document.

We reviewed the complaints recording system for the practice for the periods of 2013/2014 and 2014/2015 and found the 16 complaints were recorded and responded to within the correct timeframe. The outcome and procedures were robust and fit for purpose. We reviewed three complaints from start to finish and found them appropriately dealt with. Where appropriate we saw they had been reviewed at the multidisciplinary team (MDT) meetings within an acceptable timeframe. An MDT meeting is where a team of health and social care staff meet. It can

Good

Are services responsive to people's needs?

(for example, to feedback?)

include professionals such as nurses, GPs, social workers, psychologists and benefits workers. We saw that these had all been thoroughly investigated and the patient had been communicated with throughout the process. The practice was open about anything they could have done better, and there was a system in place to ensure learning as a result of complaints received was disseminated to staff. The process included an apology when appropriate and whether learning opportunities had been identified. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

We saw in the waiting room there was a large notice board that was titled "We're listening". This outlined previous suggestions from patients of how to improve the practice together with the actions that were taken.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity. There was a statement of purpose and this was published on the practice website.

The aim was to provide safe, high quality care that meets the needs of the patients. They stated they would provide a comprehensive, professional and friendly service with time to discuss the patient's health concerns. The practice aspired to deliver excellent outcomes for our patients.

We spoke with four members of staff and they all knew and understood the vision and values and were clear about what their responsibilities were in relation to these.

Governance arrangements

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and there were systems in place to monitor and improve quality and identify risk. All the policies were available to staff via the desktop on any computer within the practice.

Staff were aware of their roles and responsibilities for managing risk and improving quality. GPs and nurses had lead responsibilities for areas such as safeguarding, infection control and care related to patients with dementia.

All administration staff we spoke with told us that they are clear about their duties and their roles and responsibilities within the framework of practice management. There were clear escalation policies in place should the reception and administration staff feel the need to raise concerns. All staff were aware of their responsibilities and there were clear routes to obtain further clinical and non-clinical advice.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice was achieving a 93.7% score (of total available points) which compared with the local Clinical Commissioning Group average of 89.3%.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw the practice had audited the outcomes for patients on its diabetes register and also audited the use of antibiotic prescribing.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, including fire risk and issues with the practice water supply. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity to raise issues during their appraisals and at team meetings, they also told us they felt confident to raise issues. We saw from minutes that team meetings were held regularly, at least month, issues were raised by staff and there was evidence where action had been taken. Meetings took place in a formal, arranged format and informally at mid-morning coffee breaks; staff told us these provided an invaluable opportunity to share experiences and learn from others.

We saw that the practice had an active and engaged patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice. We saw that the PPG were able to feedback patients' views and concerns into the surgery. We saw an example of where a patient was able to discuss medication previously prescribed by a GP whilst having a consultation with the practice nurse. This medication was changed and in the view of the PPG represented not only that communication was effective within the surgery, but also that patients' views were respected.

Are services well-led?

Good

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

We looked at results of the latest national GP patient survey which showed that patients would recommend the practice with 86.2% responding positively as opposed to a national average of 79.1%.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients by distributing cards from the NHS friend and family test as well as patient surveys. We saw evidence on the practice website of the results of these surveys which were available for the public to view. We looked at the results of the annual patient survey and 83% of those that responded stated they found it easy to get through to the practice on the telephone. In order to ensure this level of satisfaction continues, the practice had introduced telephone consultation appointments.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG included representatives from various population groups. The PPG had carried out quarterly surveys and met but not at regular intervals. We were told a GP was present when they met. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they would benefit from training to identify a patient that was becoming seriously unwell; this was fed back to the practice who were happy to provide this internally. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

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 five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice and extended this training to medical students from the local university at all stages of their degree and had acted as examiners for their final exams. One GP was the chair of the GP trainers group and another was an elected local medical committee (LMC) representative. LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. A further two GPs served as mental health leads for the CCG. We were told that the nurses conducted their own training and we saw evidence of continuing professional development in the files of the clinicians we reviewed.

All patient referrals were peer reviewed by another GP to ensure they were appropriate and that alternate pathways had had been considered by the original GP.

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