Beechwood Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Beechwood Surgery on 11 February 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 the older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), 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. Safety incidents were investigated and learning was widely shared to improve services where needed. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients and staff were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. All staff had received support and training appropriate to their roles and any further training needs had been identified and planned for as part of staff development.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Some patients said they found it difficult to make an appointment. The appointments system was regularly reviewed to meet patients' needs and to ensure continuity of care
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Importantly the provider should:

- Ensure the performance appraisal system and personal development planning for non-clinical staff up to date for all staff, and recorded annually.

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. There were systems in place for acting on safety alerts, concerns, complaints and other incidents when things went wrong. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

The practice had a variety of procedures and protocols in place in relation to medicines management to ensure that medicines were handled, stored and disposed of safely. Medicines prescribing practices were reviewed regularly to ensure that they were safe and in line local and national guidelines and legislation.

Risks to patients were assessed and well managed. Premises and equipment were well maintained, regularly cleaned and monitored to ensure that patients were treated in a safe environment. Staff were recruited robustly and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice monitored patients uptake for reviews of long term conditions and general health screening and proactively followed these up where patients failed to attend. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely to assess and treat patients. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice provided a wide range of information, advice and screening services to help promote good physical and mental 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 clinical staff. Staff worked with multidisciplinary teams and there were good arrangements for sharing information between staff within the practice and other external health care agencies.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in the

area for several aspects of care. Patients who participated in the national GP survey in 2013 /14 rated the practice highly for how they were treated by GPs and nurses, their involvement in their care and treatment and being listened to.

Patients we spoke with during the inspection 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. Patients whose first language was not English had access to language interpretation services to help them in understanding information about their care and treatment.

We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided advice, support and information to patients, such as those with learning disabilities, mental health conditions and those with long term conditions.

The practice considered the needs of patients and their families when patients were receiving palliative care and nearing their end of life. There were procedures in place to identify and act on patients wishes. The practice provided information, support and advice to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. CCGs are groups of general practices that work together to plan and design local health services in England.

The majority of patients at the practice were in the working age group. The practice regularly reviewed its appointment system and recognised the difficulties that some patients experienced in accessing appointments. Patients could book routine appointments in advance in person, by telephone or through the on-line booking system. A proportion of daily appointments were reserved for on the day emergencies and pre-booked appointments were available on Saturday mornings. Home visits were available for patients who were unable to attend the practice due to ill health or other circumstances, including patients who lived in three local care homes.

Patients we spoke with during our inspection said they found it difficult to make an appointment with a named GP and to get same day appointments. The results of the National GP Patient Survey showed that 65% of patients who responded said that they found it easy to make an appointment that suited them. The practice was

Summary of findings

reviewing the number of lost appointments due to non-attendance by patients and they were working on educating patients about the impact this had on the availability of appointments to other patients.

The practice premises and facilities were suitable to meet the needs of patients with physical disabilities such as hearing loss or mobility difficulties. Treatment and consulting rooms were situated on the ground floor and accessible.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly and acted on issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and staff knew their responsibilities in relation to this. The ethos within the practice was to provide high quality care and treatment within a friendly and caring environment. Staff demonstrated that this was reflected in the care and treatment provided to patients.

There was a clear leadership structure and staff told us they felt supported by management. Staff said that the practice management were open and responsive to suggestions for improvement. They told us that they were involved in discussions and decision making as to how the practice was managed.

The practice had a number of policies and procedures to support staff and to govern activity.

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

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

This practice is rated as good for the care of older people. Patients over the age of 75 years had a named accountable GP who was responsible for their care and treatment. The practice identified patients who were at risk of avoidable unplanned hospital admissions. These patients were included on the practice's 'unplanned admissions avoidance' list to alert staff to people who may be more vulnerable. Regular multidisciplinary team meetings were held with other health and social care professionals to support patients and ensure that they received coordinated care and treatment.

The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments. The practice provided a range of health checks for patients aged 75 years and over. Seasonal flu vaccination and shingles vaccination programmes were provided and the practice was performing well in ensuring that patients received these vaccinations. Longer appointments were available if needed and pre-booked appointments were available on Saturday mornings. Patients with one or more long-term medical condition in the over 75 years population group and those who were identified as being vulnerable were included on a frailty register and had individualised care plans, which were reviewed every three months by the patient's named GP.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual or half yearly reviews of their health and medication to ensure that their treatment remained effective. Appointments were available with the practice nurses for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. 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.

Summary of findings

Patients had access to pre-bookable routine appointments on Saturday mornings. Patients told us staff supported and provided them with advice to help them manage their health.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be booked online, in person or by telephone. Appointments could be booked up to six weeks in advance.

Information and advice was available to promote health to women before, during and after pregnancy. The practice offered pre-conception services and post-natal check ups for babies and mothers with fortnightly appointments and clinics. The practice monitored the physical and developmental progress of babies and young children. Appointments were made available outside of school hours wherever possible.

There were arrangements for identifying and monitoring children who were at risk of abuse or neglect. Records showed that looked after children (such as those in foster care / under the care of the Local Authority), those subject to child protection orders and children living in disadvantaged circumstances were discussed, including any issues shared and followed up, at monthly multi-disciplinary meetings. GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

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

Summary of findings

offered continuity of care. Appointments could be booked online, in person or by telephone. Appointments could be booked up to six weeks in advance. Pre-bookable appointments were available on Saturday mornings.

Information about annual health checks for patients aged between 40 and 75 years was available within the practice and on their website. The Healthcare assistant or nurses offered these health checks at times to suit the patients. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the various vaccinations available including diphtheria, tetanus, polio and hepatitis A was available on the practice website. When patients required referral to specialist services, including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of patients who had learning disabilities. All patients with learning disabilities were invited to attend for an annual health check and 91% of patients had received these checks within the previous twelve months.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out-of-hours.

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 (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams to support people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

Summary of findings

Patient referrals were made to appropriate services such as psychiatry and counselling, including The Improving Access to Psychological Therapies (IAPT) and referrals to Child and Adolescent Mental Health Services (CAMHS). The practice rented space to some of these providers, which facilitated access for patients.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. Patients were provided with information how to self-refer should they wish to receive counselling.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 22 CQC comment cards patients had filled in and speaking with patients during the inspection. The majority of patients who completed comment cards told us that they were satisfied with the service they received. They commented that staff were kind, caring and helpful. Some patients told us that it was very difficult to make appointments, particularly for those who were of working age and this meant that they needed to take time off work to see a GP.

We also spoke with five patients on the day of our inspection, two of whom were involved with the practice Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Data available from the National GP Patient Survey 2013/14 showed that the practice scored in the upper range nationally for patient satisfaction with the practice. We reviewed the results from the National GP Patient Survey in which 76.8% of patients who participated would recommend the practice. The majority of patients reported satisfaction with: the practice opening hours, access to appointments, the way they were treated by staff, involvement in decision making and feeling listened to. Patients reported lower satisfaction rates in relation to access to advance routine and same day appointments.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the performance appraisal system and personal development planning for non-clinical staff up to date for all staff, and recorded annually.

Beechwood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor.

Background to Beechwood Surgery

Beechwood Surgery is located in a purpose built premises in Warley, Brentwood. The practice provides services for approximately 12,250 patients living in the south Brentwood area. Patients from up to 18 years of age account for approximately 23% of the practice population groups, 19 to 44 years 37%, 45 to 65 years 27%, 65 to 75 years 7% and 75 years and older 6%.

The practice is managed by seven GP partners and one salaried GP. At the time of the inspection, one GP was on sick leave and a GP locum was providing cover. The practice employs four practice nurses, one health care assistant and a team of administrative and reception staff who support the practice.

The practice is open between 8am and 6.30pm on weekdays with surgeries running from 8.30am to 6.30pm. Pre-booked routine GP appointments are available from 9am to 12 noon on Saturdays.

Beechwood Surgery is a teaching practice and two GPs were accredited trainers. The practice offers training opportunities and currently hosts, three trainee GPs, four medical students on short term placements and on occasion, student nurses. The practice has arrangements to advise and obtain consent from patients when students are part of consultations.

The practice had opted out of providing GP services to patients outside of normal working hours such as evenings and weekends. Details of how to access out-of-hours emergency and non-emergency treatment and advice were available within the practice and on its website.

Why we carried out this inspection

We inspected Beechwood Surgery 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, 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 visit on 11 February 2015. During our visit we spoke with a range of staff including the GPs, practice nurses, reception and administrative staff. We reviewed a number of policies and documents relating to the management of the practice. We spoke with patients who used the service. We talked with carers and family members of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with the managers of local care homes where the practice had patients.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well. There were systems for dealing with the alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the review of patients prescribed medicines and/or the withdrawal of medication from use and return to the manufacturer. The practice manager and GPs told us that GPs were responsible for reviewing MHRA and other relevant alerts, acting on these and sharing relevant information with the practice team. Staff we spoke with confirmed that this system worked well within the practice. We saw that alerts received were reviewed and shared with members of staff by way of email communications and at weekly practice meetings. Alert documents were made available on the practice shared computerised information system for staff to access. For example, we saw that if the alert related to a specific medication records were checked by the duty GP to identify any patients prescribed the item and the respective GP alerted to review the appropriateness of the treatments and to amend where this was indicated.

There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. We saw evidence that these were shared with staff and actions taken as necessary to improve safety outcomes for patients.

Complaints, accidents and other incidents such as significant events were reviewed regularly to monitor the practice's safety record and to take action to improve on this where appropriate. We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could evidence 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, accidents and near misses. Staff we spoke with said that they would report any significant or untoward event to their line manager. We saw that reporting forms were available on the computerised system and hard copies were also available and staff were aware of where to find these. We looked at records in respect of incidents, which had occurred within the previous twelve months. Incidents were discussed at clinical meetings and we found that these had been investigated and learning or changes to practice had been shared with staff. We saw examples of shared learning and changes to procedures and practices following significant events including delays in diagnosis and medication prescription errors.

Staff, including receptionists, administrators and nursing staff, told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. The practice operated in a 'no blame' culture and there were policies and procedures in place to support this. Staff we spoke with told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved. All staff we spoke with were aware of and could tell us of changes that had been implemented following serious or significant incidents.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that the all staff had received relevant role specific training on safeguarding. Staff we spoke with 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 with the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and displayed throughout the practice including in clinical rooms.

The practice had appointed two dedicated lead GPs, (and deputies), one for each area - safeguarding adults and children. Records we viewed showed that they had been trained and all clinical staff have been trained to level 3 in safeguarding children to level 3 in safeguarding children (It

is considered best practice that clinicians are trained to this level). All staff we spoke to were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. From records we saw that the GP with the lead role for safeguarding children had regular meetings with the health visitor assigned to the practice to discuss and plan for children who had been identified as vulnerable or at risk.

There was a system to highlight vulnerable patients on the practice's electronic records. GPs were appropriately using the required codes on their electronic case management system to ensure risks to vulnerable adults and children and young people who were looked after (under the care of the local authority / in foster care) or on child protection plans were clearly flagged and reviewed. Issues such as any unusual presentations or clinical concerns, information of concern raised by other professionals such as the ambulance services were considered and used to help identify adults and children who may be vulnerable. This information was recorded within the practice computerised system and used to make staff aware of any relevant issues when patients attended (or failed to attend) appointments. 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.

The practice had a chaperone policy, which was visible on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The nursing team and members of the reception staff were trained to undertake the role of chaperone. Records we viewed showed that staff had undertaken training in chaperoning patients and criminal records checks had been carried out through the Disclosure and Barring Service (DBS).

Records were kept on the practice electronic system which collated all communications about the patient including scanned copies of communications from hospitals and information from the out-of-hours service. We saw evidence that staff had undertaken training in the use of the electronic system and audits were carried out to assess the completeness of these records.

Medicines Management

We saw that medicines used in the treatment of patients such as vaccines and emergency medicines were stored appropriately and securely and accessible only by authorised staff. Medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure they did not fall outside the temperature range recommended. The practice had suitable policies and procedures in relating to the receipt, handling and storing temperature sensitive medicines such as vaccines to minimise their exposure to heat.

Processes were in place to check medicines were within their expiry date and suitable for use. Records were maintained to show that these checks were carried out regularly. All the medicines we checked were within their expiry dates. We saw records which indicated that all expired and unwanted medicines were disposed of in line with waste regulations.

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

We saw the practice held annual medicines management meetings and monthly prescribing meetings to review and monitor their prescribing practices. There were suitable procedures for reviewing patients' medicines and repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The GPs discussed the arrangements for the management of high risk medicines such as disease-modifying anti-rheumatic drugs (DMARDs) used in the treatment of rheumatoid arthritis. These medicines may, but rarely have serious side-effects the blood, liver or kidneys. GPs told us that patients who were prescribed these medicines had their blood tests carried out at the hospital and that these were reviewed when authorising repeat prescriptions.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. The majority of patients told us that that the repeat prescription service worked well and they had their medicines in good time. They also confirmed that their prescriptions were reviewed and any changes were explained fully. Some patients reported delays in obtaining

their repeat prescriptions. The practice had acted on these comments and had recently introduced electronic prescription service which was used by approximately 35% of patients and was proving to be more effective.

Cleanliness & Infection Control

The practice had appropriate policies and procedures in place to protect patients and staff against the risk of infections. Patients we spoke with during the inspection and those who completed comment cards told us that they found the practice was always clean and that they had no concerns. We observed the premises to be clean, tidy and uncluttered. Hand sanitising gel was available for patient use at the booking in screen in the reception area. These were posters promoting good hand hygiene displayed throughout the practice. Hand washing sinks with hand soap and hand towel dispensers were available in treatment rooms and toilet facilities.

The practice employed an external cleaning company and the practice manager met regularly with the company to discuss the cleaning arrangements and to resolve any issues should they arise. A staff communication book was available at reception where staff could record any issues identified in relation to the cleanliness of the premises. We saw there were detailed cleaning schedules in place for daily, weekly and periodic cleaning tasks for general and clinical areas. Cleaning records were kept to show when cleaning had been carried out. The practice had arrangements for monitoring the infection control procedures. The practice had arranged with other local GP practices to carry out infection control audits and an infection control audit had been carried out in November 2014. The audit identified areas for improvement and there was a plan in place, which identified who was responsible for implementing the changes required and the timeframe for doing so.

There were infection control policies and procedures for staff to follow, which enabled them to plan and implement control of infection measures. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. Staff were provided with appropriate personal protective equipment including disposable gloves and aprons. Spillage kits were available for cleaning and disposing of body fluids. We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice ensured that only single use disposable instruments were provided for all minor operations they performed. We saw that the practice had arrangements and notices in place for the segregation of clinical waste at the point of generation. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles. We saw evidence that all clinical staff had undertaken infection control training and clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. Advice and information was provided so as to help patients protect themselves against the risks of infections. Information and advice was available about the Ebola virus and the practice had a dedicated isolation room available should a patient present at the practice with symptoms of the virus.

The practice manager and one practice nurse shared the role of lead for infection control. From records viewed we saw that both had undertaken further training to enable them monitor and oversee the infection control procedures within the practice. We reviewed the minutes of practice meetings and saw that infection prevention and control updates and issues were discussed as needed.

The practice had conducted a risk assessment to identify and manage the risks associated with legionella (a germ found in the environment which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory, minor surgery and diabetes clinic. Staff 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 labelled to indicate the dates on which these tests had been carried out. Records we viewed showed that relevant

equipment such as weighing scales, spirometer, thermometers, ear syringe and the fridge thermometer were calibrated in line with the manufacturer's instructions so as to ensure that this equipment was fit for use. Through discussion with staff and a review of records we saw that equipment was serviced and replaced as needed.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. Over half of staff working at the practice had done so for 10 years or more. The practice manager reported a lower than average rate of unplanned leave due to sickness, which helped to ensure consistency and continuity of the services provided to patients. We reviewed five staff records for staff including two members of staff who had been appointed within the previous 12 months. Records included proof of identification and evidence of each person's qualifications and registration with the appropriate professional body, such as the Nursing and Midwifery Council (NMC) for nurses and the General Medical Council (GMC) for GPs where appropriate. We saw that appropriate references and criminal records checks through the Disclosure and Barring Service (DBS) had been obtained for all clinical staff. However employment references and DBS checks had not been obtained for all administrative staff. A risk assessment had been conducted and the practice manager confirmed that these checks would be carried out for all staff where the risk assessment indicated.

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.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, which staff were aware of. Risks were assessed using reference from the Health and Safety Executive (HSE) guidance and appropriate risk assessment records were completed, monitored and audited to ensure that the practice environment, equipment and staff practices were safe.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they were aware of these procedures. For example staff had access to policies and procedures for treating sudden deterioration in patients including children and treating patients in the event of a mental health crisis. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients. For example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

GPs we spoke with could demonstrate that they had considered the risks associated with medicines prescribed in the treatment of patients who had mental health conditions. We saw that the practice had appropriate systems in place for reviewing patients' medicines every six months or more frequently if required.

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 medicines and 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 asked, all members of staff knew the location of this equipment. Records we viewed confirmed that this equipment was checked regularly. There were protocols in place for dealing with medical emergencies including the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Anaphylaxis kits were available in dedicated parts of the practice to treat patients in the event of allergic reaction to medicines. Staff were able to describe how they would act in the event of patients requiring emergency treatment and how they supported these patients.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as loss of power, adverse weather, staff

Good

Are services safe?

shortages or other circumstances that may affect access to the building and services. The plan identified the actions staff should take and who to contact in the event of any such incident.

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 and that fire equipment was inspected periodically to ensure that it was in safe working order. Fire evacuation procedures were displayed throughout the practice and staff were aware of the procedures to evacuate the premises in the event of a fire or other incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patient care and treatment was delivered in line with recognised best practice standards and guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to patient care and treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), and the Clinical Commissioning Group guidelines and policies. Staff told us that information and any changes in legislation or national guidelines were shared during regular clinical staff meetings. Records we viewed confirmed this. Data we reviewed showed that the practice's performance assessing and treating patients with long term conditions such as diabetes, asthma, chronic respiratory diseases and heart disease were generally in line with or above that the local Clinical Commissioning Group (CCG) and national averages. The practice was also performing well for the uptake of all childhood vaccinations and immunisations, flu vaccinations and cervical screening.

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. We saw that all patients received appropriate treatment and regular review of their condition. The practice used computerised tools to identify and review registers of patients with complex needs, for example, patients with learning disabilities or those with long term conditions including diabetes and health promotion. The GPs and nurses told us they led in specialist clinical areas diabetes, COPD and asthma. They told us that the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with told us that there was a very open culture within the practice for seeking advice and support from colleagues.

Staff told us that information relating to patients who accessed the out-of-hours services and patients' test results were reviewed by GPs on a daily basis. We saw evidence that when patients were discharged from hospital, their patient records were sent to the patient's GP for review and that any changes to medication or on-going treatments were recorded appropriately.

Records we viewed showed that the practice had low accident and emergency admission rates for their patients demonstrating that treatments and advice provided were effective.

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. A dedicated GP (who had trained as a GP) was responsible for summarising records and this helped to minimise errors in recording information about patient's diagnosis and treatments.

The practice participated in all the enhanced service from the clinical commissioning group (CCG), Public Health and NHS England. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.) The practice achieved 98.6% of the maximum points for Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice was providing a good service relation to assessment and treatment of patients.

The practice had a system in place for carrying out clinical audit cycles. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. At the time of our inspection the practice had completed a number of audit cycles. We looked at two clinical audits which had been carried out. The first audit reviewed the practice prescribing for Domperidone (used in the treatment of nausea and sickness) following a Medicines and Healthcare Products Regulatory Agency (MHRA) alert in 2014. This medicine may cause a small risk of serious cardiac side-effects, particularly in patients over 60 years. Following the clinical audit the practice reduced the prescribing of Domperidone by 40%. A second audit looked at the prescribing of Risperidone (an antipsychotic drug used in the treatment of schizophrenia) to patients with dementia. The results of the audit showed that the practice was following the National Institute for Health and

Good

Are services effective?

(for example, treatment is effective)

Care Excellence (NICE) guidelines. Both audits had been reviewed which demonstrated that the practice was effective in monitoring and changing, where required, the treatments provided to patients.

The practice protocol for repeat prescribing was in line with national guidance and staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also monitored the routine health checks carried out for patients with long-term conditions such as diabetes, asthma and chronic heart disease and for patients with learning disabilities and those with mental health conditions.

The practice kept a register of patients receiving palliative care. The practice held regular bi-monthly multidisciplinary meetings working to the Gold Standards Framework. These meetings were were well attended by external professionals such as the Macmillan nursing team to help ensure that patients with life limiting conditions were treated and supported appropriately.

Effective staffing

The practice employed staff who were suitably skilled and qualified to perform their roles. Over half the staff working at the practice had done so for 10 years or more. Records we viewed showed that appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We spoke with staff and reviewed staff records and saw that all staff were up to date with training including annual basic life support, infection control and fire safety. GPs we spoke with told us that they had specific interest areas such as dementia, diabetes, sexual and family health. The practice held ten training half days per year for clinical staff to undertake training updates in areas including care of patients with Parkinson's disease, dementia, stroke and cancer. It also provided the same number of training sessions for non-clinical staff for training and practice arranged consultants to come to speak on topics of specific interest.

All GPs were up to date with their yearly continuing professional development requirements and all had either completed their revalidation or had a date set for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.). Beechwood Surgery is a training practice. Two GPs are trainers and there were robust systems for supporting and monitoring trainee GPs, medical students. The practice also has the facilities and trained nurse mentors to support student nurses, which happens on a regular basis throughout the year.

Staff including practice nurses and the health care assistant had clearly defined roles within the practice and were able to demonstrate that they were trained to fulfil these duties. All clinical staff undertook annual appraisals of their performance from which learning and development needs were identified. Records viewed showed that staff had individual personal development plans in place. Staff we spoke with confirmed that the practice was proactive in providing training and funding for relevant courses. The practice also had systems in place for identifying and managing staff performance and providing support and further training to assist staff should they fail to meet expected standards. We saw that while training and development opportunities were provided for non-clinical staff for non-clinical staff, not all of these had an up to date written record of their most recent appraisal of performance.

Working with colleagues and other services

The practice worked with other service providers, including social services, the local hospital trust and community services to meet patients' needs and support patients with complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. One GP gave us an example of how they facilitated the continuity of care when a patient moved to another area. They told us how they prepared a detailed summary of treatment the patient was receiving for the patient to take with them to their new GP, as this GP did not have access to the shared electronic system. This helped to ensure that delays were minimised in the patient receiving appropriate care and treatment.

The practice held quarterly multidisciplinary team meetings. Relevant community health and social care professionals were invited to review and plan care and treatment for patients, such as those who with life limiting

illnesses and vulnerable patients. Staff felt that these meetings and the use of the electronic patient recorded system worked well to maintain a comprehensive record of health interventions. The practice had an established system for patient referral to external services for assessments, treatment or advice.

The practice manager also engaged with other local practice managers through meetings on a monthly basis, hosted at the practicefor support and advice on issues relating to primary medical services. The practice provided care and treatment to patients who resided in local care homes. Regular meetings were held and annual patient reviews were conducted to help ensure that patients received appropriate care and treatment. We spoke with the managers of two of these homes and they confirmed that the GPs at the practice provided consistent care and treatment to patients who lived there. They commented that it was easy to obtain advice and to request GP visits as needed.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, 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.

The practice used several electronic systems to communicate with other providers. For example, the community nursing team and health visitors had access to the patient records where patients had consented to the sharing of their medical information. Electronic systems were also in place for making referrals, and the practice made the majority of their referrals last year 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.) Staff reported that this system was easy to use.

The practice had ensured the electronic Summary Care Records were completed and accessible on line. Summary Care Records provide access to key clinical information for healthcare staff, not working at the practice, treating patients in an emergency or outside of normal hours. The practice has explained the Summary Care Records system to patients and had ensured that those who dissented from having a Summary Care Record did not have one made available online.

Consent to care and treatment

The practice had policies and procedures in place for obtaining a patient's consent to care and treatment where people were able to give this. The policy covered documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients consent before carrying out physical examinations or providing treatments. Patients we spoke with confirmed that their treatment, options available, risks and benefits had been explained to them in a way that they could understand. They told us that their consent to treatment was sought before the treatment commenced.

Staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties to meet the requirements of these legislations when treating patients. 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. Nurses and GPs we spoke with told us how they considered parental responsibilities when obtaining consent before treating children.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they and/or their carers were involved in agreeing, where they were able to do so. 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 help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

Good

Are services effective?

(for example, treatment is effective)

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room, reception and entrance hall where patients could see them. These included information to promote good physical and mental health and lifestyle choices. We saw information about promoting and maintaining physical and mental health, domestic violence advice and support was prominently displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation, alcohol consumption and substance misuse. There was information available about local and national help, support and advice services. This information was available in written formats within the practice and on the practice website.

Information about the range of immunisation and vaccination programmes for children and adults, including MMR, Shingles and a range of travel vaccinations were well signposted throughout the practice and on the website. Data we viewed for 2013/14 showed that the practice performed at or above the local and national averages for the uptake of standard childhood immunisations, seasonal flu vaccinations, cervical screening (smear tests) and annual health checks for patients with one or more long-term health condition such as diabetes and respiratory diseases. We saw evidence that the practice had identified and contacted patients who were eligible for vaccines such as shingles vaccines for patients in the eligible groups aged 70,78 and 79 years and 75% of patients had received these vaccines. Over 75% of patients aged over 65 years had received their annual flu vaccination and 91% of patients who had a learning disability had received their annual health check. At the time of our visit we saw that the practice was monitoring its performance for 2014/15 and was proactively targeting patients who had failed to attend appointments for healthcare screening, immunisations and annual health checks.

The practice offered a full range of health checks. All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice had identified and offered appropriate smoking cessation support to patients through dedicated smoking cessation appointments made at convenient times for patients..

At the time of our inspection the practice was promoting the male cancer awareness month and a range of information and advice was displayed within the patient waiting area.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013/ 14 national GP patient survey, and a survey of 400 patients undertaken by the practice in 2014. We saw that patients responded positively indicating that they received a caring service. For example, 84% of patients who completed the national GP patient survey said that the last GP or nurse who were good at treating them with care and concern. This was higher than the local average rating of 79%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. The majority of patients commented that they were listened to and involved in making decisions about their care and treatment. We also spoke with patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There were signs in the waiting areas and consulting rooms explaining that patients could request a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish so.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk, which helped keep patient information private. Private facilities were available to speak with patients away from the public reception area to maintain patient confidentiality. We also saw that there were arrangements in place for the secure disposal of confidential records and information.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was a policy and procedure in place to support and manage patients who displayed abusive behaviour. Staff told us how they would try to immediately diffuse the situation and accommodate patients' needs wherever possible.

Care planning and involvement in decisions about care and treatment

GPs told us that patients were provided with information in relation to their care plans either verbally or in writing. The outcomes from multidisciplinary team meetings such as palliative care and unplanned hospital admissions actions were recorded in each patient's medical notes. The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed the majority of practice respondents said the GP involved them in care decisions and they felt the GP was good at explaining treatment and results. Both these results were similar to or higher than the average compared to the local Clinical Commissioning Group (CCG) area. The results from the practice's own satisfaction survey showed that patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice had reviewed the needs of patients whose first language was not English and had identified 59 patients.

Good

Are services caring?

The practice had arrangements in place for accessing language interpretation services, as required. These were intended to support and help patients understand and engage in making decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and supporting patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were invited to provide this information at the point of registration. We saw that there was a variety of written information available for carers to help them access support and advice organisations. There was a dedicated carers' noticeboard in the waiting area. This was managed by the receptionist appointed and trained as carers' champion

Patients who we spoke with during the inspection and those who completed comment cards and participated in national and practice surveys all commented positively about the emotional support they received. Patients spoke of the compassion and care shown to them by all members of staff including GPs, nurses and reception staff.

The practice had procedures for supporting bereaved families. Staff told us that if families had suffered bereavement, their usual GP contacted them by telephone and appointments or home visits were arranged as needed. The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed. The GPs worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families.

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 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. These were led by Clinical Commissioning Group (CCG) targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities.

The premises were purpose built and included appropriate facilities to meet the needs of patients. The practice facilities included 10 GP consulting rooms, three nurse consulting rooms and a counselling room. Space was rented out to other services including counsellors, Improving Access to Psychological Therapies (IAPT) and community ultrasound service (Beehive), Retinal screening and Aortic Aneurysm screening. This assisted some patients to access a number of services within one location.

Vulnerable patients such as those with a drug and alcohol addiction or suffering with poor mental health were signposted to external organisations that could provide support to them, including services provided onsite. In addition to seeing their GP the practice runs a "shared care" programme for patients with drug addiction.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They had policies and procedures for promoting diversity and equality. For example less than 1% of the patient population did not speak English as their first language. Patients had access to telephone language interpretation services.

The practice had registers of people who may be living in vulnerable circumstances and those with mental health conditions or learning difficulties. Staff were able to give examples of how these helped them deal sensitively with patients. For instance, offering extra support to patients to attend or longer appointments, whilst also signposting patients to the range of services available within the local community.

The premises and services were suitable to meet the needs of patient with disabilities for example the entrance was accessible via a ramp. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8.30am to 6.30pm on weekdays and two pre-booked GP surgeries were available from 9am to 12 noon on Saturdays for routine appointments. 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. The practice website provided information about the availability of GPs some of whom worked part time and the website informed patients of days when GPs did not work to assist them in booking appointments with their preferred GP. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The majority of the practices' patients were in the 19 to 65 years age group. Patients' levels of satisfaction with the appointments system were variable. Four of the five patients we spoke with told us that it was often very difficult to get a pre-booked or an on the day appointment. They said that they could normally get a non-urgent appointment within a few days and one said they could see a doctor on the same day if they needed to. These levels of satisfaction with the appointments system were also reflected in the NHS England national GP survey 2013/14, the GP patient survey and reviews of the NHS Choices website. For example,33% of patients with a preferred GP indicated in the national patient survey 2013/14 that they got to speak with or see that GP, 76% said that they had been able to get an appointment the last time

Good

Are services responsive to people's needs?

(for example, to feedback?)

they tried and 65% of patients indicated that they were overall happy with the appointments system. These results were considerably lower than the local Clinical Commissioning Group averages, which were 62%, 84% and 73% respectively. The practice told us that some dissatisfaction with patients being able to see their preferred or favourite GP could be accounted for in the turnover of trainees who changed every six months.

The results of the practice patient survey were similar to the national GP survey data, with patients commenting that it was very difficult to get appointments. Eight of the 22 patients who completed CQC comment cards and four of the five patients we spoke with during the inspection also reported difficulties in accessing appointments. Some patients commented that they had to wait up to three weeks or a month on occasions to get a routine non-urgent appointment.

We discussed these findings with the practice manager and GPs. We were told that the practice provided access to over 4,500 nurse and GP appointments each month. The practice reported that the majority of patients preferred to see their favourite GP and this impacted on the choice of appointments, especially as a number of the GPs worked on a part time basis. They also told us that one GP was due to return from a period of absence and that this would increase satisfaction with seeing choice of GP, as currently a locum GP was providing those appointments lost due to the absent GP partner.

The practice had a higher than average non-attendance, had seen an increasing frequency in the number of patients who failed to attend pre-booked appointments over a two year period. The practice manager monitored the rate of missed appointments and showed us evidence of these. We saw that over 200 appointments were lost each month as a result of patients failing to attend and failure to cancel their appointment. We saw that the practice and the Patient Reference Group had done some work to educate patients and this had helped to reduce the number of missed appointments.

In order to help patients access on the day appointments the practice had introduced a system for keeping three 'book on the day' appointments for each GP and nurse every morning and afternoon. This was in addition to the duty doctor having emergency appointments all day and the nurses having book on the day appointments. This system was being monitored. The practice had monitored the patient demand for same day appointments. In response they had allocated 60% of Monday morning appointments to book on the day, so as to help provide prompt access to patients who had accessed the out-of-hours service over the weekend or who had waited to attend the practice with an acute problem that arose over the weekend.

The practice offered regular GP visits to the two large local care homes which provided accommodation to their patients. Each care home had a named GP and weekly visits were carried out to review and monitor patients health. Daily urgent visits were also provided as needed. The managers from these homes confirmed that the system worked well and that they were able to get advice and to book on the day appointments when required.

Overall we saw that the practice worked proactively to meet the needs and wishes of patients in relation to providing a flexible appointments system, including offering routine booked appointments on Saturday mornings to assist working aged patients.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that where complaints made were about clinical issues such as assessments, diagnosis or treatments that these were investigated and responded to by GPs.

We saw that information was available to help patients understand the complaints system and information advising patients on how to complain or raise concerns were contained in the patient leaflet, on the practice website, and displayed within the patient waiting areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. However they told us that they felt confident that their concerns would be taken seriously; investigated and responded to fairly.

We reviewed a sample of complaints made within the previous year. We saw that these had been fully investigated and responded to in a timely manner. Where complaints were substantiated the patient was then contacted with a full explanation and where necessary an

Good

Are services responsive to people's needs?

(for example, to feedback?)

apology was made. Patients were advised of what actions they could take should they feel that their complaints had not been dealt with fairly or where they remained dissatisfied with the outcome. Details of how to refer their concerns to NHS England and the Ombudsman were accessible and included in responses to patients complaints.

The outcomes and any issues from ongoing complaints were discussed at practice meetings, or where necessary on a one to one basis with staff members or as part of their appraisal. The practice was able to demonstrate learning and changes as a result of complaints. We saw that complaints were monitored and reviewed regularly to help identify and trends or themes in patients dissatisfaction and to learn from and act on these and improve patients experiences.

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 and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these. The practice philosophy was described in the patient information leaflet and on the practice website. The practice had a business and future planning strategy in place, which it reviewed regularly.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews and listening to staff and patients.

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared network, accessible from any computer within the practice. We looked at a number of these policies and procedures found that they were relevant.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP partners took lead roles for safeguarding, end of life care and the management of long term conditions such as asthma and diabetes. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing higher than or in line with national standards. We saw that QOF data was regularly discussed at regular clinical team meetings and action plans were produced to maintain or improve outcomes.

A number of clinical audits were carried out in the practice. These were used to monitor patient treatment in line with changes to national and local guidelines and to act on alerts such as medicines alerts to help improve outcomes for patients. From a review of records including minutes from staff meetings, appraisals, complaints and significant event recording we saw that information was regularly reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments.

Leadership, openness and transparency

All staff we spoke with told us that GPs and the practice management team were supportive and approachable. They told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held weekly meetings and met more frequently when required, to discuss any issues or changes within the practice.

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

The practice sought feedback from patients on a regular basis. The practice had an active Patient Participation Group (PPG). A PPG is made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. We spoke with two members of the PPG and they told us that the practice was open to and acted on, where possible, the suggestions made by the group. They told us that the group met every six to eight weeks and that patients who wished to participate but were unable to attend meetings could contribute virtually by email. The PPG carried out patient surveys and the results from these were made available to patients as they were displayed in the patient waiting area. The results from the most recent survey, carried out in 2014 showed that patients were satisfied with the services they received at the practice. The results of the survey identified areas where improvements were needed such as how to meet increasing patient

Are services well-led?

Good

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

demand for appointments and the number of appointments lost as a result of patient's failure to attend. The PPG were working with the practice to identify potential solutions to these issues.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they were supported to actively contribute and give their feedback, comments and suggestions. 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 signed by, and available to all staff and those we spoke with said that they would feel confident in reporting any concerns.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff, the majority of whom confirmed that they received annual appraisals where their learning and development needs were identified and planned. Not all non-clinical staff had an up to date annual appraisal of their performance. However they told us that they were supported in personal development and learning. Staff told us that the practice constantly strived to learn and improve patients' experiences and to deliver high quality patient care.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had protected time for learning and personal development.