Feltwell 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

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Overall summary

Letter from the Chief Inspector of General Practice

We visited Feltwell Surgery on the 22 January 2015 and carried out a comprehensive inspection.

We found that the practice was good overall across all the areas we inspected.

Our key findings were as follows:

- The practice had a good understanding of the needs of the practice population and services were offered to meet these.
- Patients were satisfied with the service and felt they were treated with dignity, care and respect and involved in their care.
- There were systems in place to provide a safe, effective, caring and well run service. 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 care and treatment.

There were areas of practice where the provider should make improvements.

The provider should:

- Ensure staff have a clear understanding of the Mental Capacity Act and their role in implementing it.
- Ensure there is a procedure in place for handling and recording all dispensing errors and near misses.

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. The practice was able to demonstrate that they provided safe services that had been sustained over time. There were processes in place to report and record safety incidents and learn from them. Staff were aware of the systems in place and were encouraged to identify areas for concern, however minor. Staff meetings and protected learning time were used to learn from incidents and clear records had been kept including any action taken. Risks to patients were assessed and well managed. Infection control procedures were completed to a satisfactory standard. There were enough staff to keep people 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. Staff referred to guidance from the National Institute for Clinical Excellence (NICE), acted upon updates and referred to the guidance routinely. The practice adopted the Gold Standards Framework for the treatment of people nearing the end of their lives and requiring palliative care. Peoples' needs were assessed and care was planned and delivered in line with current legislation. The performance of the practice across key health areas was regularly monitored to ensure it achieved targets. Health promotion advice was readily available and patients signposted to external organisations and internal services to receive support. Staff were supported in the workplace, received annual appraisals to measure their competence and were trained appropriately. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff worked with multidisciplinary teams to ensure patients received the best care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly. Patients we spoke with and those who had taken part in surveys said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information was available at the practice that helped patients understand their condition and the services that were available to them both externally and within the Feltwell surgery. Staff treated patients with kindness and compassion and treated information about them confidentially. Patients with caring responsibilities were supported.

Summary of findings

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 mostly 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. There was a complaints system in place that was fit for purpose; we saw that complaints received had been dealt with in a timely and responsive manner.

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 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 care of older people. It was responsive to their needs. Home visits and priority appointments (including for patients who were receiving palliative care) were available and prescriptions could be delivered to their home address by the practice dispensary. Multi-disciplinary team meetings took place for elderly people with complex needs. External support was signposted and made available for them to access. Elderly patients had a named GP to receive continuity of care. Telephone consultations were available. The practice was pro-active in encouraging patients to receive flu and pneumococcal vaccinations.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group who might have a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check 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.

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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments with GPs and nurses were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and community services. Antenatal care was referred in a timely way to external healthcare professionals. Parents we spoke with were positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

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 at the practice which reflected the needs for this age group.

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. The practice held a register of patients living in vulnerable those with learning disabilities. Annual health checks for people with learning disabilities were undertaken and patients received annual follow-ups. 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.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice worked closely with West Norfolk Carers and offered a range of support and advice to carers in the community. The practice had ensured staff were trained as carer champions to ensure patients received the support when and where they needed it. 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 aware of the different types of abuse that could occur.

People experiencing poor mental health (including people with dementia)

Good

The practice proactively identified patients who may be at risk of developing dementia. The practice were aware of the number of patients they had registered who were suffering from dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being 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 when they were discharged back to their 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, IAPT and the community psychiatric nurse for provision of counselling and support. However not all staff had a clear understanding of the Mental Capacity Act and their role in implementing the Act.	

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. The practice had 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 22 comment cards and one letter from a patient to the CQC, all indicated that patients were more than satisfied with the support, care and treatment they had received from the practice. Comments cards also included positive comments about the efficiency and professionalism of the staff, the appointment availability, the safety and cleanliness of the practice, the skills of staff, the way staff listened to their needs and being pleased with the on-going care arranged by practice staff. However one comment reported a long wait fro appointments with a specific GP and another expressed concerns at being asked by reception to describe their medical problem.

The feedback from patients we spoke with was positive. Patients told us about their experiences of care and praised the level of care and support they received at the practice. The patients we spoke with told us they were happy with the service and they felt they got good treatment. We were told the GPs and nurses always gave them plenty of time during their consultation. They told us that staff explained things and clinicians gave them sufficient time and information to be able to make decisions with regard to their treatment and care. Patients told us that the GPs, nurses and receptionists were very supportive and they thought the practice was well run. Patients were able to describe to us how there had been effective communication between the GPs at the practice and other services. Patients knew how to complain, but told us they mostly had no complaints. Those patients who told us they had raised a complaint with the practice, told us they felt the practice had listened to their concerns and dealt with them appropriately.

Patients told us they could get an appointment when it was convenient for them and with the GP of their choice. Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity and the GPs and nursing team were very approachable and supportive.

Patients confirmed that they were happy with the supply of repeat prescriptions. Patients told us they would recommend the practice and were happy with the practice facilities.

There was a supply of health care and practice information on display around the waiting room area.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff have a clear understanding of the Mental Capacity Act and their role in implementing it.
- Ensure there is a procedure in place for handling and recording all dispensing errors.

Feltwell 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, a CQC Pharmacy inspector and a practice nurse specialist advisor.

Background to Feltwell Surgery

Feltwell Surgery provides general medical services Monday to Friday from 8am to 6.30pm. The practice provides primary medical services to approximately 4713 patients and is situated in central Feltwell near Thetford, Norfolk. The practice was originally established in 1818. The newer purpose built premises provide good access with accessible toilets and disabled car parking facilities. The practice offers extended appointments mornings and evenings to enable better access for patients.

The practice has a team of four GPs meeting patients' needs. Two GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there were two practice nurses, two healthcare assistants, a dispensary manager, lead dispenser and a team of dispensers, dispensing assistants and an apprentice dispenser. In addition there is a practice manager, assistant practice manager, a team of medical administrators, secretaries, summarisers, receptionists and cleaners. The practice provides a dispensary on site.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, counsellors, support workers and midwives.

The practice provides services to a diverse population age group, in a semi-rural location.

Outside of practice opening hours a service is provided by another health care provider, by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 22 January 2015. During our inspection we spoke with a range of staff including GP partners, practice nurses, health care assistants, dispensers, reception and administrative staff and the practice manager. We spoke with patients who used the service. 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 23 comment cards and one letter 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, compliments 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. For example, staff recorded reported incidents to the GPs or practice manager as electronic tasks and were able to demonstrate to us the process they used to confirm these had been seen by a senior member of staff and responded to. These included patient complaints and any safety concerns.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these 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 systems in place for reporting, recording and monitoring significant events. Learning from safeguarding reviews was communicated internally at significant event and practice meetings. In addition any learning from safeguarding reviews was shared externally at the multi-disciplinary team (MDT) Vulnerable and End of Life patients meetings. There was evidence that the practice had learnt from significant incidents and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration both outside and within meetings and they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. 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 and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak both internally and externally if they had a safeguarding concern.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system SystmOne, which collated all communications about the patient, including scanned copies of communications from hospitals. 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.

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, patients diagnosed with dementia or those requiring additional support from a carer.

A chaperone policy was in place. Chaperone training had been undertaken by all nursing staff, including health care assistants. Staff told us that nursing staff were mostly used when chaperoning patient. However where nominated reception staff were asked to chaperone, we saw they had received the appropriate chaperone training and the practice had undertaken security checks to identify any potential risks to patients.

Records we saw showed that staff at the practice had been subject to criminal checks through the Disclosure and Barring Service.

Medicines Management

We noted the arrangements in place for patients to order repeat prescriptions. Patients we spoke with and their representatives told us they received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. The practice had monitored and assessed the quality of its dispensing service. The practice provided a medicine delivery service for patients who lived in rural areas and had established a service for people to pick up their dispensed prescriptions at a nearby village. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Good

Are services safe?

There were arrangements in place for the security of the dispensary so that it was only accessible to authorised staff. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. We noted there were arrangements in place for the regular monitoring and destruction of controlled drugs. We checked a sample of controlled drugs and found we could account for them in line with registered records. However, we discussed with the practice manager and dispensary manager the improvements required to record controlled drugs carried in doctor's bags once they had been supplied from the dispensary. We were told the practice would put systems in place to record and monitor controlled drugs kept in these bags.

The dispensary manager told us the procedure for discussing issues arising including when there were medicine-related incidents. However, we noted there had been fewer medicine- related incidents including near-miss dispensing errors recorded than had actually arisen. We noted that policy documents relating to medicine management and dispensing practices were regularly updated and members of dispensary staff were informed of and acknowledged any changes. However, there was no written procedure for handling dispensing errors.

The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. Dispensary staffing levels were in line with DSQS guidance. Records showed that members of staff involved in the dispensing process were appropriately qualified and their competence was checked annually.

Processes were in place to check medicines were within their expiry date and suitable for use. Medicines for use in an emergency were monitored for expiry and checked regularly for their availability. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery.

Cleanliness & Infection Control

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 to be clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Bags and gloves were available for staff to use when handling specimens.

There were infection control policies in place. There was also a policy for needle stick injury. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury. We found that the practice had clinical and reception staff trained in infection control and the spillage kits were in date and accessible.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

Equipment

Staff we spoke with told us they had sufficient 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 blood pressure monitors.

Staffing & 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 via the Disclosure and Barring Service. There was a recruitment policy that set out the standards the practice followed when recruiting clinical and non-clinical staff. We checked the records of four staff. The records showed that staff were interviewed, and criminal records checks were carried out. Staff were provided with contracts of employment.

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 systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular daily checks of the building and the environment.

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: There were emergency processes in place for patients with long-term conditions or on end of life care. There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as severe weather or staff illness. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis.

Staffing establishments including staffing levels and skill mix were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and appropriate levels of staff well-being.

Staff told us they felt happy they could raise their concerns with the practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role. Staff described what they would do in urgent and emergency situations.

Emergency medicines and equipment were available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly.

We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

Staff confirmed if they had daily concerns they would speak with the GPs, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinicians in the practice.

There was information displayed in the reception area, in the patient leaflet and practice website regarding urgent medical treatment both during and outside of surgery hours.

Arrangements to deal with emergencies and major incidents

We saw records which demonstrated that both clinical and non-clinical staff had received training in Basic Life Support within an appropriate time frame. All staff we asked knew the location of the Automated External Defibrillator, oxygen and records we saw confirmed these were checked regularly. 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,

Good

Are services safe?

anaphylaxis and hypoglycaemia. Processes were also in place to check 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included access to the building, power failure, unplanned illness and adverse weather conditions. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. Staff told us regular fire drills were undertaken.

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 (NICE) 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.

We found that clinical staff had a system in place to receive relevant updates about new guidelines and that these were then put into practice to improve outcomes for patients. There were GP leads in specialist clinical areas such as mental health, dementia, epilepsy and diabetes. The nurses supported this work, but led on areas such as asthma, chronic obstructive pulmonary disease (COPD), smoking cessation and diabetes management. The dispensary manager was the nominated practice champion for prescribing and attended quarterly prescribing educational meetings. Together with the GP prescribing lead they also attended bi-annual meetings with the local CCG to ensure the practice was effectively adhering to the most recent guidelines on prescribing and local prescribing initiatives. Members of the clinical and administrative team took a lead in different areas of care in line with the Quality and Outcomes Framework indicators. The Quality Outcomes Framework (QOF) provides a set of indicators against which practice are measured and rewarded for the provision of quality care.

The practice took part in the admissions avoidance scheme; vulnerable elderly patients who were most at risk of being admitted to hospital had been identified and a care plan created which identified the patient's carers, social services and community nursing team and next of kin. All patients over 75 registered at the practice had a named GP, there were also named GPs and care coordinators for each patient on the practice admissions avoidance register. The care coordinators were members of staff who had a knowledge of the patient and reviewed their records on a quarterly basis to check if they had been seen recently at the practice, if not, the care coordinator then contacted the patient to ensure they were well and had no outstanding health care needs. Patients on the admission avoidance register were flagged on their electronic medical records to ensure that they would have same day access to a clinician. The practice had identified patients at risk of dementia and offered a Test Your Memory test undertaken by the trained healthcare assistant. Patients with a poor score were then referred to their GP who referred them on to the necessary support service. The practice had consistently achieved one of the highest dementia diagnosis pick up rates in Norfolk.

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. GPs attended training sessions and undertook e-learning modules that provided them with clinical updates so that their learning was continuous. Clinical 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.

Patients we spoke with on the day told us that they were satisfied with their assessments and felt that their needs were met by the clinicians. Patients received appropriate advice about the management of their condition including how they could improve the quality of their lives. We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission and end of life care. The practice ensured care plans were accessible to other agencies, such as out of hours services to ensure their full involvement and to facilitate sharing of information. The practice referred patients appropriately to secondary and other community care services.

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 were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. One GP told us the practice did not have a regular cycle of clinical audits in place. However, we saw audits were generated on a regular basis as a result of CCG initiatives, for example minor surgery audits, infection control audits and prescribing such as methotrexate audits.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, care coordinators and managing child protection alerts and medicines management. There were systems in place to identify patients at risk who had not attended for health reviews or flu vaccinations. Alerts were added to patients' computer records to notify the clinician if these were overdue. This ensured the clinician would be aware and able to undertake the review or vaccination should the patient arrive for an appointment for a separate healthcare need. The administration team also carried out follow up phone calls to either make an appointment for the review or flu vaccination, or record if the review or flu vaccination had been declined. The information staff collected was then collated by the GPs to support the practice to carry out clinical audits.

The practice showed us one clinical audit into ovarian cancer that had been undertaken in the last year. This audit was prompted by a GP attending an educational meeting. This was a completed audit, we saw that the outcomes had been discussed and agreed at clinical meetings and the practice was able to demonstrate the learning and changes following the initial audit.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results.

There was a protocol for repeat prescribing which was in line with national guidance. Patients receiving repeat prescriptions had been reviewed by the GP. Medicines were reviewed annually or more frequently when necessary. Repeat prescriptions were not issued until the patient had attended the practice for their medication review. All new prescriptions were checked and authorised by one of the GPs prior to being given to a patient.

The practice had implemented the Gold Standards Framework for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. The practice maintained 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. We looked at the minutes of the palliative care and end of life meetings and found that individual cases were being discussed and care and treatment planned in line with patients' circumstances and wishes.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included clinical, managerial, dispensary and administrative staff. We viewed training records and found that all staff had received annual basic life support and safeguarding of children and vulnerable adults. Staff had also been trained in the use of the equipment used at the practice. Training of all staff was regularly reviewed.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation, (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The practice had recently recruited administration and reception staff from the West Suffolk College apprentice scheme.

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed these included

Good

Are services effective?

(for example, treatment is effective)

reviews of performance and the setting of objectives and learning needs. All of the GPs within the practice had undergone training relevant to their lead roles, such as child safeguarding.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, practice nurses provided minor illness clinics, diabetes, asthma and chronic obstructive pulmonary disease (COPD) monitoring and administration of childhood and travel vaccines. Healthcare assistants provided phlebotomy, INR monitoring, weight monitoring, ear syringing, smoking cessation, electrocardiograms (ECGs) and Test Your Memory for Dementia dementia screening. We saw that the practice nurses and healthcare assistants had been provided with appropriate and relevant training to fulfil their roles.

Reception and administrative staff had undergone training relevant to their role. One member of staff who had joined the practice within the last 6 months described their induction programme which included supervision, group training and e-learning programmes. Staff described feeling well supported to develop further within their roles.

Where GP locums were used, their qualifications and experience were checked prior to working at the practice. We noted a good loyal skill mix among reception, administrative and clinical teams with some staff having been employed by the practice for over twenty years.

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

The practice effectively identified patients who needed on-going support and helped them plan their care. We also saw how the practice spoke and worked collaboratively with other surgeries to the benefit of its patients. Patients from other practices in the area were offered access to the practices' intrauterine contraceptive device (IUCD) fitting service and anticoagulant blood monitoring service. The practice provided a designated room at the premises for other services such as the fortnightly midwifery clinics, monthly West Norfolk Carers clinics, fortnightly dietician clinics, monthly hearing aid clinics and weekly wellbeing clinics for patients with depression or mental health requirements.

The practice held monthly multidisciplinary team 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 the GPs, practice nurses, dispensary manager, community nurses, community matron and the integrated care team. Decisions about care planning were documented in a shared care record. Staff told us this system worked well and the forum was effective as a means of sharing important patient information. The practice manager told us the practice had worked closely with the MacMillan GP for West Norfolk to review the practice model for the care of palliative care patients. We saw the feedback was positive and staff were praised for the work in place.

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.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Electronic systems were also in place for making some referrals through the Choose and Book system.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's security and ease of use. The practice used information received to ensure patient care was being planned effectively. For example, the practice received hospital data on admissions and A&E attendances daily. This information was disseminated to the patient's named GP, via the electronic clinical system, by an administrator within the practice.

The practice also has signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

Consent to care and treatment.

There was a practice policy for documenting consent for specific interventions. For example, cervical smears, childhood immunisations and minor surgical procedures. Patients' verbal consent was documented in their electronic patient notes. We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. These provided staff with information about supporting patients with reduced capacity to make decisions in their best interest capacity.

The practice had access to a telephone translation service. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

All staff were aware of patients who needed support from nominated carers and clinicians ensured that carers' views were appropriately taken into account. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Reception staff were able to give clear examples of how they would ensure young patients had access to clinicians.

The practice told us that it has not been necessary to use restraint within the last 3 years. Staff were nevertheless aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and teenage health reviews, sexual health advice and free condoms. Smokers were encouraged to see the practice nurse who had received training to support patients wishing to give up smoking. Dieticians held fortnightly clinics at the practice to support patients in maintaining a healthy body weight.

Staff showed us and told us about the new patient's registration pack which included an alcohol users disorder identification test, a new patient health questionnaire, a patient ethnic origin questionnaire, a medication information questionnaire, consent of patient care data information sharing and an opt out request for patients from the NHS Summary Care Record and a request for patient feedback on the service provided by the practice. Clinical staff told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

The practice offered NHS Health Checks to all its patients aged 40-75 and these checks were undertaken by the practice nurse. The performance of the practice in this area was the subject of regular monitoring and data reflected that targets were being achieved.

The practice identified patients requiring additional support. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. These patients attended appointments for their annual review of their condition and ongoing treatment was followed up by the practice. Care plans in place were regularly reviewed. Weekly counselling clinics were provided at the practice by Wellbeing Services.

Good

Are services effective?

(for example, treatment is effective)

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice was pro-active in identifying patients through posters in the surgery the information screens in reception, letters to patients and telephone calls. Travel vaccinations were also available. There was a clear policy for following up non-attenders.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about support services, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients and their relatives and carers to organisations such as: the Alzheimer's society, Help the Aged and West Norfolk Carers, who held monthly drop in clinics at the practice to provide support and advice for patients and their carers. The practice took part in a pilot project with West Norfolk Carers to identify carers in the community and ensure they received the care and support they required. As a result of working with West Norfolk Carers the practice had implemented carer champions in the practice with training support from West Norfolk Carers, a carer support pack, recording of carers in their records and priority to carers to accommodate appointments. In addition the practice displayed carer information on the practice website, in the practice leaflet and on the TV monitor in the waiting area; the practice also provided patients with the Message in a Bottle pack. This was a means of storing emergency health information including personal details, GPs name and number, medical conditions, allergies, carer details and next of kin contact numbers in a sealed container within a patients fridge in their home. A sticker on the outside of the fridge alerted emergency services to its location and reduced time in accessing these details.

There was a large range of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone, victim support and support for patients and their carers on the noticeboards and information monitors in the reception 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 national patient survey with a 41% completion rate and a survey of patients undertaken by the practice's Patient Participation Group with a 32% response rate. The evidence from these sources showed patients were highly satisfied with how they were treated and that this was with kindness, dignity and respect. For example, data from the national patient survey showed 100% of the respondents had confidence and trust in the last GP and nurse they saw, 96% responded that the nurses were good at treating them with care and concern, 98% responded that the nurses were good at giving them enough time and explaining their treatments, 94% responded that the last GP they saw was good at giving them enough time, 95% of respondents reported the GP was good at listening to them. 94% reported the receptionists to be helpful and 95% reported they found it easy to get through to the surgery by phone.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and one letter to CQC and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were professional, caring, kind and experienced. They said staff treated them with dignity and respect. We also spoke with seven patients who told us they were very satisfied with the care provided by the practice and said they were treated with compassion and 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. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Patients we spoke with were aware of the availability of chaperones if they required them and were able to give us examples of their experiences with a chaperone present during their consultation.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us 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 they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The more vulnerable patients such as the elderly with complex needs, patients with long term conditions and those suffering from dementia were monitored regularly through the use of care plans. Where appropriate, the views of relatives were sought and explanations provided to help them understand the best type of care and treatment that met people's needs.

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 patient survey showed 92% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results. The results from the practice's own patient satisfaction survey showed that 100% of patients responded they were very or fairly satisfied with their care. Patient feedback on the comment cards we received was also positive and aligned with these views

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.

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

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

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

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice had a system for ensuring that all staff were informed of the death of a patient. This was to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient. Patients were supported by the practice when a close relative died. The waiting area included various information which sign posted people to support available including citizen's advice, counselling and bereavement services. A named GP visited patients towards the end of their lives and supported family members alongside the community matron and nursing team. Traumatic events such as a death or loss of a child during pregnancy were identified and support offered including signposting to other services. If the service was unable to meet the patient's needs they could refer the patient to trained counsellors and mental health support. Staff we spoke with said that patients at the end of their life and their family were provided with whatever support they needed. Patients and staff we spoke with described the service staff provided patients, by personally transporting vulnerable and frail patients to and from the surgery for their appointments when there were no other public transport services available.

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. We found that the practice understood the needs of the patients using the service and the services were tailored to patients' needs to ensure flexibility, choice and continuity of care.

Patients could request to see a GP of their choice and this was accommodated on most occasions. Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. Although patient appointments were generally of ten minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues. Patients we spoke with told us they did not feel rushed during their appointment, that the GPs listened and understood their concerns, explained things to them and gave them the time they needed. Patients over 75 years of age had a named GP to ensure continuity of care for the elderly.

The appointment system was effective for the various population groups that attended the practice. Patients told us they were satisfied with access to consultations for both GPs and nurses.

Patients were able to request repeat prescriptions online, via the dedicated dispensary telephone line or to attend the practice personally. Prescriptions would be ready within 48 hours; however patients we spoke with told us that they were often ready for collection earlier.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Tackle inequity and promote equality

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice had recognised the needs of different groups in the planning of its services. All the treatment and consultation rooms were situated on the ground floor. There were accessible toilets and baby changing facilities were available. The practice had access to a telephone translation service.

The appointment check-in facility in the practice was set up to reflect the most common languages in Feltwell. Staff had access to an interpretation and translation service. They were able to demonstrate an awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. We saw evidence of staff supporting people who were unable to use the booking-in screen or read the appointment information monitor in the reception area.

Patients who were homeless were able to use the practice's address to register as a temporary patient.

Access to the service

Appointments were available daily from Monday to Friday in the morning and afternoons. The practice closed early Tuesday afternoon, however there was a reciprocal arrangement with a neighbouring practice where patients could attend for urgent appointments. Patients could also register to book appointments online. The practice offered early morning appointments for GP and nurse led appointments on Tuesdays from 7.30am and late evening appointments on Mondays until 7.00pm.

Priority was given to patients with emergencies and to children. Some appointment times were blocked off for this purpose. They were seen on the same day wherever possible. We spoke with six patients on the day who told us that they had been able to get appointments for themselves, their family members or their children when required.

Patients could select their GP of choice if they were available. Chaperones were readily available for patients to use on request and the practice offered a text appointment reminder service

The practice nurses ran separate clinics for people with long term conditions such as asthma, diabetes and hypertension. There were health promotion appointments available at the practice, such as for smoking cessation, intrauterine coil insertion or removal and anticoagulant monitoring for patients from the practice and neighbouring

Good

Are services responsive to people's needs?

(for example, to feedback?)

surgeries and dietician led clinics. This gave patients greater flexibility to choose where they would prefer to attend rather than travelling to local hospitals for these services.

Signs were available in the reception and waiting room area that explained the appointment system. It also explained how to obtain emergency out of hour's advice through the 111 system.

Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a double appointment where necessary to ensure all healthcare needs could be adequately discussed.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system. The practice offered a home delivery service to patients who were unable or too unwell to collect their medication. Staff were familiar with patients who suffered from dementia and provided telephone calls to remind the patient of an upcoming appointment, in some cases we were told staff would collect the patient from their home and bring them to the surgery for their appointment, returning them back to their home afterwards.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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.

Listening and learning from concerns and 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.

All staff were aware of the complaints procedure and were provided with a protocol that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. 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 that complaints recorded in the last 12 months had been dealt with in a timely manner. Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required

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 provide a patient centred service with the emphasis on the total patient experience and to promote good outcomes for patients.

The practice vision and values included continually questioning the way in which services were provided to ensure continued improvement of patient care, and to offer best care and personal service along with a wide range of modern services.

They had an up to date statement of purpose that clearly described their objectives, vision and strategy. Staff spoken with were aware of the direction of the practice and were working towards it.

Staff job descriptions and appraisals supported the direction in which the practice wished to head and they were clearly linked to the vision and objectives. Staff felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available for staff to read. We viewed several of these policies and found that they had been reviewed annually and were up to date. Policies included infection control, chaperones, whistleblowing, complaints and comments and safeguarding.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for respiratory and infection control, the senior partner was the lead for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. Staff 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. This is an annual incentive programme designed to reward good practice. The QOF data for this practice showed it was performing above local CCG and national standards. We saw that QOF data was regularly discussed at weekly team meetings and action plans were produced to maintain or improve outcomes. Team meetings were used to discuss issues and improve practises. We looked at minutes from the last three clinical and staff team meetings and found that performance, quality and risks had been discussed.

The practice had a programme of clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken. These included QOF performance, infection control and 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 health and safety and fire risk assessments. 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. For example risks identified from significant events, patients comments and complaints. These were clearly identified and reviewed on a regular basis to ensure that patients and staff were safe.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. As all clinical staff attended the practice on Monday and there was protected time each week for clinical, educational and governance meetings. The practice manager told us there was a culture of care, support and good work-life balance amongst the staff. Administration and reception staff worked part-time and were multi skilled in various roles across the practice, this ensured the practice could continue to operate efficiently at all times. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. There was a willingness to improve and learn across all the staff we spoke with. However not all clinical staff had a clear understanding of the Mental Capacity Act or could describe their roles and responsibilities regarding its implementation. We discussed this with the GPs and practice manager who agreed to put improvements in place regarding improved staff training on the Mental Capacity Act and its implications.

The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was a low turnover of staff with some staff remaining in employment with the practice for over 20 years. The practice manager told us the team-oriented approach and

Are services well-led?

Good

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

support for a sustainable work-life balance created the stability and performance that came from long serving and competent staff. Staff told us the practice held regular practice functions where staff and their families were welcome, we were told these proved to be effective team building exercises.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment, induction and whistleblowing policy, which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control. The members of staff we spoke with were all clear about their own roles and responsibilities.

Seeking and acting on feedback from patients, public and staff

The practice no longer had an active PPG. However we saw they were actively recruiting patients to a virtual patient participation group (VPPG). The practice had gathered feedback from patients through annual surveys, complaints and compliments, the previous patient participation group (PPG) and suggestion boxes within the waiting room area. The PPG is a group of patients registered with the practice who have an interest in the service provided by the practice. We looked at the results of the 2014 annual patient survey, 94% of respondents stated they would recommend the practice to someone new to the area, 82% of respondents described their experience of making an appointment as good and 100% of respondents reporting they were very or fairly satisfied with their care and treatment. Patients reported that doctors and staff were helpful and sympathetic, staff were always friendly, patients felt well cared for and they were very satisfied.

Areas for improvement identified from this survey included the time it took for the telephone to be answered, appointment availability and the height of chairs in the waiting area. The practice manager told us these issues had been acknowledged by the practice and actions were being taken to monitor, and make improvements in, these areas. These included nurse appointments during extended hours sessions.

The practice gathered feedback from staff through team meetings and the appraisal process. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. As well as the mandatory training such as basic life support and fire safety, staff were offered the relevant training to suit their specific job description. For example the administration team had received training in medical terminology, dealing with difficult situations and telephone calls. The dispensary manager had achieved their BTec in dispensing in general practice and the dispensers were all trained to NVQ level 2 in dispensing and had all completed NVQ level 2 in customer services. The practice had recently taken on apprentices from a local college who had been enrolled in the NVQ in customer services.

We viewed records that effective appraisal processes were in place that had been maintained over a number of years. Staff files reflected that training had been identified and provided to staff to enable them to meet the needs of the patients. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients Audits, the results of a patient survey and the analysis of significant events were used to improve the quality of services. Where audits had taken place these were part of a cycle of re-audit to ensure that any improvements identified had been maintained. The practice had recently implemented a Performance Improvement Register; this audit tool identified areas highlighted for improvement following meetings or incidents such as clinical governance meetings or safeguarding training. The proposed improvement was identified with any actions required including training needs, a completion and review date. The practice manager told us it was hoped this would provide a useful monitor of improvements across the practice.