The Central 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

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 5

What people who use the service say 7

Outstanding practice 7

Detailed findings from this inspection

Our inspection team 8

Background to The Central Surgery 8

Why we carried out this inspection 8

How we carried out this inspection 8

Detailed findings 10

Overall summary

Letter from the Chief Inspector of General Practice

We visited Central Surgery on the 2 October 2014 and carried out a comprehensive inspection.

The overall rating for this practice is good, with areas of outstanding for effective and responsive care.

Our key findings were as follows:

- 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.
- There was a good understanding of the needs of the practice population and services were offered to meet these.

We saw areas of outstanding practice including:

- The practice employed a nurse practitioner to manage and coordinate care for patients in care homes
- The practice employed a health care specialist with fitness training to support patients improve their quality of life.
- The practice provided a fully equipped gym to assist patients with their quality of life improvements.
- The practice employed a mental health counsellor to support patients who have mental health needs.
- The practice provided a care support worker to support patients, their families and their carers.

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 had systems in place to safeguard vulnerable patients from the risk of harm. Safeguarding policies and procedures were in place for both children and vulnerable adults. This enabled staff to recognise and act on concerns in relation to abuse. The practice had a robust process in place for recruiting staff to work at the practice. This included checking the registration of nurses and GPs,

There were effective systems in place to minimise the risk of infection.

There was appropriate emergency medical equipment and medicine available.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were not only up-to-date with both NICE guidelines and other locally agreed guidelines but we also saw evidence that confirmed that these guidelines were influencing and improving practice and outcomes for their patients. We saw data that showed that the practice is performing highly when compared to neighbouring practices in the CCG. The practice is using innovative and proactive methods to improve patient outcomes and it links with other local providers to share best practice.

Are services caring?

Good

The practice was caring. Patients and carers we spoke with described the service provided as good. The patients we spoke with felt they were listened to and respected. Patients told us they were involved in decisions about their care and treatment. Patients told us they were treated with dignity and respect by both non-clinical and clinical staff.

Are services responsive to people's needs?

Good

The practice was responsive to people's needs. The practice worked effectively with other health and social care services to ensure patients received the best outcomes. We found that the practice understood the individual needs of patients and made reasonable adjustments accordingly. The practice sought engagement with patients to gather feedback on the quality of the service provided and responded to the feedback in order to improve the service.

Summary of findings

Are services well-led?

Good

The practice was well-led. There was a clear leadership and management structure. The partners and the practice manager we spoke with understood how they needed to take forward the practice in the future to improve patients' experiences. There was a commitment to learn from feedback, complaints and incidents. The nursing team had been restructured to improve efficiency and meet patients' expectations. We saw that staff had an annual appraisal to enable them to reflect on their own performance with the aim of learning and improving the service. Staff told us they felt well supported. There was evidence of a range of team meetings, which included department meetings and whole practice meetings. There was an emphasis on seeking to learn from stakeholders, in particular through the local clinical commissioning group (CCG) and the patient participation group (PPG). This is a group of patients registered with the practice who have an interest in the service provided by the practice.

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

Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. The practice funded a gym and instructor to meet the needs of their elderly population and improve mobility and pain management. The practice provided support to local care homes, and patients who wished to remain in their own homes. Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for their care.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. The practice provided regular health care reviews for patients with a range of long term conditions. The practice outcomes for childhood immunisations, cervical smear uptake and Quality Outcomes Framework (the Quality Outcomes Framework (QOF) provides a set of indicators against which practice are measured and rewarded for the provision of quality care) were above the local CCG averages despite operating at reduced staffing levels. There was support and education provided to patients with conditions such as diabetes, smoking cessation or obesity. The practice funded a gym and instructor to meet the needs of their patients with long term conditions and improve mobility and health management. The practice held regular multi-disciplinary team meetings to manage the care of patients nearing the end of their lives.

Families, children and young people

Good

The practice offered lifestyle advice to pregnant patients. The practice worked with local health visitors, midwives and school nurses to offer a full health surveillance programme for children. The practice ran healthy lifestyle/weight loss classes for young people and mothers. Checks were also made to ensure the maximum uptake of childhood immunisations. Health and advice checks were available for 15 year old patients.

Working age people (including those recently retired and students)

Good

The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the

Summary of findings

services it offered to ensure these were accessible, flexible and offered continuity of care. The practice ran healthy lifestyle/weight loss classes working age patients. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice was accessible for any vulnerable group and offered general medical services to a local woman's refuge.. The practice had identified patients with learning disabilities and treated them appropriately. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation. The practice offered telephone consultations and contact via email. The practice provided a care support worker to help patients who were carers. There was a booking in touch screen in the reception area with a variety of languages available for people whose first language was not English. A hearing loop for patients who had hearing impairments. The practice used a telephone translation line to provide a confidential translation service to people whose first language was not English.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people living in vulnerable circumstances. The practice funded a mental health counsellor to improve access for patients who were experiencing poor mental health. Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with severe mental illnesses. The practice worked in conjunction with the local mental health team and the community psychiatric nurses and provided a support worker for weekly clinics at the practice. The practice ensured that patients with poor mental health were able to access the practice at a time that was suitable for them. The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.

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 15 comment cards, many of which contained detailed positive comments about the caring and compassionate attitude of the staff. Comments cards also included positive comments about the skills of staff, the way staff listened to their needs and being pleased with the on-going care arranged by practice staff. These findings were also reflected during our conversations with patients. Two comment cards raised concerns at the availability of appointments and detailed their difficulties in getting through to the practice on the telephone.

The feedback from patients was mainly 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 said they were happy and they got good treatment. Patients we spoke with told us the GPs and nurses always gave them plenty of time during the consultation to explain things. We were told the clinicians were very good with the patients and there had been effective communication between the GPs at the practice and specialists at the hospitals and other services. Patients told us that the GPs were very supportive and they thought the practice was well run. Patients knew how to complain but told us they mostly had no complaints.

Patients told us the appointment system was improving and they could mostly get an appointment when it was convenient for them. 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 were very approachable and supportive.

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

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

Outstanding practice

- The practice employed a nurse practitioner to manage and co-ordinate care for patients in care homes.
- The practice employed a heath care specialist with fitness training to support patients improve their quality of life.
- The practice provided a fully equipped gym to assist patients with their quality of life improvements.
- The practice employed a mental health counsellor to support patients who have mental health needs.

The Central Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP.

Background to The Central Surgery

The Central Surgery provides general medical services Monday to Friday from 8am to 6.30pm. The practice provides primary medical services to approximately 13,700 patients and is situated in central Gorleston, Great Yarmouth. The building provides good access with accessible toilets and disabled car parking facilities.

The practice has a team of five GPs meeting patients' needs. Four GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there was one salaried GPs, one advanced nurse prescribing practitioner, six registered nurses including a nurse practioner, a healthcare specialist with qualifications in advanced fitness instruction, gym, nutrition and weight management, a team of healthcare assistants and receptionists who also saw patients for phlebotomy consultations, a practice manager, a finance manager and reception and administrative staff. The practice also provided a mental health counsellor and a carer support worker.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, counsellors, support workers, health visitors 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 (Integrated Care) that patients access by using 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 inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before conducting our announced inspection of The Central surgery, we reviewed a range of information we held about the practice we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We held a listening event where patients and members of the public shared their views and experiences of the service.. We carried out an announced inspection on 2 October 2014. During our inspection we spoke with and interviewed a range of staff including GPs, the practice manager, the practice nurses, reception and administrative staff. We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took

Detailed findings

place. We spoke with eight patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We observed how staff dealt with patients in person and over the telephone. We discussed anonymised patient care plans.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable.
- People experiencing poor mental health

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. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. The practice were able to demonstrate that it had systems in place to report record and analyse significant events. We saw that where meetings had taken place learning outcomes were shared with staff.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. For example prescription errors and a recent failure of a vaccine fridge. Staff knew that following a significant event, the practice manager and GPs undertook a Significant Event Analysis (SEA) to establish the details of the incident and the full circumstances surrounding it.

We reviewed safety records and incident reports and saw minutes of meetings where these were discussed for the last year. 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 and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. A slot for significant events was on the practice monthly meeting agenda and a dedicated meeting occurred quarterly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system used to audit and monitor each incident. We tracked seven incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example the practice had put procedures in place to ensure abnormal results were referred where appropriate.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts these were stored on a practice electronic folder on the computer system to ensure all staff had access to any relevant to the practice and were aware of action needed to be taken.

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 all 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. 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. Contact details were easily accessible.

The practice had dedicated GP's appointed as leads in safeguarding vulnerable adults and children who had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (e.g. level 3). All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, patients diagnosed with dementia or learning disabilities.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including the Health Care Assistants. Staff were informed about their role and the implications for protecting both the patient

and the GP. Clinicians documented that a chaperone had been offered and either accepted (with name of chaperone) or declined by the patient, in the patient record.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system EMIS Web, which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to review of prescribing data. For example, patterns of warfarin prescribing for patients diagnosed with a deep vein thrombosis (DVT) within the practice.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Members of the nursing staff were qualified as independent prescribers and received regular supervisions and support in their role as well as updating in the specific clinical areas of expertise for which they prescribed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

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.

Cleanliness and 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 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. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence of an infection control audit completed by the Commissioning group Infection Control lead in January 2014. The practice achieved an overall 92% in infection control; improvements were identified for action with a time scale for completion. Practice meeting minutes showed the findings of the audits were discussed and addressed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy. There was also a policy for needle stick injury, and spillage kits available.

Good

Are services safe?

Hand hygiene techniques signage was 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 weighing scales and blood pressure monitors.

Staffing and recruitment

We looked at the staff rota and the practice appointments rota. We saw that staffing was monitored and reviewed daily by the practice and business manager. However, the practice manager told us there were no formal systems in place for this. We were told by the practice manager, and staff confirmed that administrative and receptionist staff rotated roles and all staff were knowledgeable of each other's roles and were therefore able to stand in for each other in times of absence or busy periods. We saw there was a rota system in place for all the different staffing groups to ensure they were enough staff 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. Newly appointed staff had this expectation written in their contracts.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, professional registration checks for all clinical staff with the Nursing and Midwifery Council (NMC) or the General Medical Council (GMC). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice manager told us that safety checks with the Disclosure and Barring Service (DBS) for clinical staff had been performed. Risk assessments for those non-clinical staff who would work with vulnerable people, had been performed.

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 ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Staff we spoke with confirmed if they had any concerns they would ask any of the GP's, the practice manager, the nurses or the reception manager for support and advice. Staff felt their concerns were listened to and acted on.

Monitoring safety and responding to risk

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or 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 (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 levels of staff well-being. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies, this included responding to busy periods. For patients with long term conditions there were emergency processes in place. Staff gave us examples of referrals made for patients that had a sudden deterioration in health.

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 and knew what to do in urgent and emergency situations.

There was emergency medicines and equipment 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 and the equipment was available and fit

for purpose. 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 were able to describe how they had put this training to good effect recently when a patient's health had deteriorated.

Staff confirmed if they had any concerns they would speak with the GP's, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinician's 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 demonstrating that all staff had received training in Basic Life Support within the last two years (for non-clinical staff) and year for clinical staff. All staff asked (including receptionists) knew the location of the Automated External Defibrillator, oxygen, pulse oximeter and nebuliser. In the notes of the practice's Significant Event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place. The practice had also received a thank you letter from the patient thanking the staff for their swift action.

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 power failure, adverse weather and localised sea flooding, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of local practices and services in the event of localised flooding and lack of access to the premises.

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 and that regular fire drills were undertaken.

Risks associated with service and staffing changes were included on the practice risk log. We saw an example of this where the practice were undergoing an exercise to develop future service plans against assessed risks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with best practice standards. The GPs told us they lead in specialist clinical areas such as heart disease, diabetes and asthma.
The nurse practitioner, practice nurses and HCAs supported this work which allowed the practice to focus on specific conditions. A nurse practitioner is a clinician who is an advanced practice registered nurse who has completed advanced coursework and clinical education beyond that required of the generalist registered nurse role. All clinicians we interviewed were able to describe and demonstrate how they accessed both guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. We were told that revised NICE guidelines were identified and shared with all clinicians appropriately. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The clinicians we interviewed demonstrated evidence based practice. All GPs and nurses demonstrated how they accessed guidelines from NICE and from local commissioners. We saw agendas of practice meetings where new guidelines were itemised for review and discussion. We were told any changes were implemented and the use of them monitored. All the GPs we spoke with were aware of their professional responsibility to maintain their knowledge.

The GPs had access to online prescribing support systems. These systems ensured that the GPs were prescribing in line with national and local guidelines and that their prescribing decisions offered patients effective treatments.

We found that patients had their needs assessed and that their care was planned and delivered in line with guidance and best practice. Patients were referred in line with guidance and best practice to secondary and other community care services. The practice had also completed a review of case notes for patients with urinary tract infections which showed they were on appropriate treatment with regular reviews. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed by their GP where appropriate. We saw appropriate use of the Two Week wait referrals, (two week wait referrals are a fast track referral system for managing urgent referrals for patients with suspected cancers). We saw minutes from meetings where regular review of elective and urgent referrals were made, we saw that improvements to practise were shared with all clinical staff.

We saw that care and treatment decisions were based on people's needs without unlawful discrimination. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The nurse practitioner undertook weekly ward-rounds for patients in two care homes under the practice's care to proactively manage and co-ordinate care. The practice health care specialist was qualified with appropriate fitness training qualifications. They ran healthy lifestyle/weight loss classes for the young, those of working age and mothers. They also provided support to meet the needs of the elderly and those patients with long term conditions to improve mobility and manage pain. This included mobility conditions, cardio vascular disease (CVD) and weight loss. The healthcare specialist worked with patients in the improvement of their health and fitness and the use of the fitness equipment provided in the practice gym.

We saw that the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose the typical range of conditions patients might present with. The practice provided patients and staff with a fully equipped gym. This equipment included a running machine and exercise bikes and was used in conjunction with the healthcare specialist to support patients in improving their mobility, manage body weight and maintain a healthy lifestyle.

We saw that care and treatment decisions were based on people's needs without unlawful discrimination. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice used The Quality and Outcome Framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that they generally achieved high or very high scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed consistently above in comparison to other practices within their CCG area. Staff spoke positively about the culture in the practice around clinical audit and quality improvement.

The Practice has a system in place for completing clinical audit cycles. We saw that Central Surgery had undertaken clinical audits on prescribing and referrals. The practice was undertaking a clinical audit in the prescribing of anticoagulant medicines (anticoagulants are medicines used to reduce the ability of the blood to clot), for patients diagnosed with a deep vein thrombosis (a thrombosis is the formation of a blood clot within a vein). We saw that the practice had completed clinical audits in the use of antibiotics in the diagnosis of urinary tract infections, and the appropriateness of patients referred to the Ear, Nose and Throat departments of local hospitals.

The practice participated in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess performance. The practice liaised closely with district nurses, the multidisciplinary team coordinator and the out of hour's service to try and reduce unplanned admissions. The practice held regular multi-disciplinary meetings to discuss the most vulnerable patients and to organise the care required to keep patients in their own homes when appropriate to do so.

Effective staffing

Practice staffing included clinical, nursing, managerial and administrative staff. We reviewed five staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. We saw that the 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).

We saw that staff were appropriately qualified to carry out their roles safely and effectively in line with best practice. There were effective induction programmes. The learning needs of staff were identified and training put in place. Staff felt well supported in the training programme. Staff told us that training opportunities and their requests for training had never been refused. We saw the staff training record which showed that staff were up to date with mandatory training including basic life support, infection control, fire safety and safeguarding of vulnerable adults and children.

The practice manager told us that poor performance was identified during observation of staff performance and in the staff appraisal process, and addressed with staff as a training or development requirement.

The practice manager told us that local practice managers had an email link where they could email questions for support and advice. The practice manager attended local practice manager meetings, some of which the local CCG facilitated. We were told these were useful for support and development.

Working with colleagues and other services

The practice held regular palliative care meetings. Palliative care and treatment was offered to patients with cancer and other life limiting illnesses, who were identified as approaching the end of their lives. This was confirmed by the GPs who advised that all patients with palliative care needs were reviewed during these meetings. We looked at the meeting agendas and saw these were attended by GPs and representatives of the community care team.

The practice shared information with the out-of-hours service, for example special patient notes about patients with complex health needs. The practice adopted the Gold Standards Framework for the treatment of people nearing the end of their lives and requiring palliative care (GSF).The GSF encourages clinicians to talk to patients nearing the end of their life, their families and their carers about how and where they wished to be cared for and to work together to provide a plan to meet their care requirements.

The practice employed an advanced nurse practitioner who visited two local care homes weekly and whom the

Good

Are services effective?

(for example, treatment is effective)

care homes could contact should they have any concerns. The practice manager told us the nurse practitioner also provided guidance on care to staff working at the services. There was a dedicated telephone number available for the care homes, ambulance control, accident and emergency service at the local hospital, the community team, mental health team and social care team to use which was answered quickly and ensured prompt access to a GP or care co-ordinator. The practice also provided general medical services to the local woman's refuge.

The community cancer matron worked closely with patients who had been diagnosed with cancer to provide them with care and support as they required. The practice worked closely with the community matron, whose role was to work closely with patients in the community to provide, plan and organise their care. The practice offered a carer support worker who held weekly clinics at the practice to offer advice and support carers; the support worker also visited patients and their carers in their homes if they were unable to attend the surgery. The practice employed a mental health counsellor who held weekly clinics at the practice for patients. There was also evidence of working closely with local organisations by offering the use of facilities within the practice to see patients who may not otherwise have the opportunity to be seen locally. For example diabetic eye screening service and local mental health support workers.

Information about patients who had contacted the out of hours service, had been admitted to hospital, were seen in hospital clinics or had been discharged from hospital were reviewed daily by GPs at the practice.

Results of tests received by the practice, such as blood or urine results were seen by the GPs. There were systems in place to ensure these were seen and actioned and patients were contacted where necessary.

The practice used digital speech dictation software to dictate referrals and patient letters to other organisations. This ensured that letters could be dictated directly on to the computer system and attached to patient's records. Potential errors and corruptions of dictation recordings were minimised and the system provided a clear audit trail of the referral, from the time of dictation, the GP dictating the referral to the processing of the letter.

Information sharing

The practice held regular palliative care meetings. Palliative care and treatment was offered to patients with cancer and other life limiting illnesses, who were identified as approaching the end of their lives. This was confirmed by the GPs who advised that all patients with palliative care needs were reviewed during these meetings. We looked at the meeting agendas and saw these were attended by GPs and representatives of the community care team. The practice shared information with the out-of-hours service, for example special patient notes about patients with complex health needs.

Information about patients who had contacted the out of hours service, had been admitted to hospital, were seen in hospital clinics or had been discharged from hospital were reviewed daily by GPs at the practice. Results of tests received by the practice, such as blood or urine results were seen by the GPs. There were systems in place to ensure these were seen, actioned and patients were contacted where necessary.

The practice had systems in place to provide staff with the information they needed. An electronic patient record 'EMIS WEB' 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 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.

Consent to care and treatment

There was a practice policy for 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. We were shown an audit that confirmed the consent process for minor surgery had been recorded as being followed in 90% of cases. The practice manager informed us all clinicians had since been reminded of the need to record consent on patient's records.

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. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity was an issue, the practice had drawn up a policy to help staff, for example

Good

Are services effective?

(for example, treatment is effective)

with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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.

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).

The practice was involved in teaching medical students from the University of East Anglia. In order for the students to cover various medical conditions as part of their learning, the practice contacted patients and asked them if they would be prepared to come to the surgery and be seen by the GP and the medical students. If patients agreed, they were invited to attend at a convenient time and complete a consent form which was scanned onto their medical records. We saw that if a patient stated they do not wish for medical student to be present, the GP was informed and the practice ensured the student left the room during the consultation.

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

Health checks were offered for all patients registered at the practice between the ages of 40 and 74 years of age, patients diagnosed with chronic diseases and those over 75 years of age. Patients with long term health conditions or who were prescribed repeat medications were seen by a GP to review their repeat medications. Staff told us that patients who were unable to visit the practice were offered health care checks, diabetic education and phlebotomy services in their own home.

Information on a range of topics and health promotion literature was available to patients at the practice and on the practice website. This included information on safeguarding vulnerable patients, requesting a chaperone and victim support. 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. There was information about services to support them in doing this, such as smoking cessation advice. We saw there was a clear process the practice followed for patients who did not attend for cervical smears.

The practice was registered for the C-Card scheme. Practices registered for the scheme offered free condoms to patients in the Norfolk and Waverney area between the ages of 13 and 24 years of age. In order to obtain a C-Card, patients were required to register and meet with a C-Card worker at the practice. Information on sexual health was provided to all patients registering for the scheme. Information on sexual health was also available to all patients who did not qualify for the C-Card scheme.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients, their relatives and carers to organisations. Information on a range of topics for carers and patients was available on the carer's notice board in the waiting room. A carer support worker held weekly clinics at the practice to offer advice and support to carers; visits were provided to patients at home if they were unable to attend the surgery. The practice worked closely with the local drugs and alcohol team. The counsellor provided weekly consultations to appropriate patients.

A diabetic specialist nurse held regular clinics at the practice for patients who required additional help with their diabetes.

Flu vaccinations were offered to all pregnant patients, patients over the age of 65 and those in the identified at risks groups. A one off Pneumococcal vaccination was offered to patients over 65. The practice offered a full range of immunisations for children and travel vaccines for adults and children in line with current national guidance. This included a catch up Human Papilloma virus (HPV) vaccine programme for female patients, who although they fit the national guidelines for vaccination, may have missed the vaccine provided through the schools programme.

Good

Are services effective?

(for example, treatment is effective)

There was a large range of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone and victim support.

The practice kept a register of all patients with learning disabilities. Nursing staff received training on managing these patients. However the practice had not offered annual health checks to all patients in this group. The practice manager told us they were looking to commence this in the very near future.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed patients and those close to them being treated with respect and dignity by staff in all roles at the practice. Patients who used the service told us they felt supported and well-cared for. We saw that staff responded compassionately to patients in discomfort or emotional distress. We noted that staff approached people in a person centred way; we saw they respected people's individual preferences, habits, culture, faith and background.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the practice patient survey. This included a survey of 15 housebound patients and 305 patients undertaken by the practice. The evidence from this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example; data showed of the 320 patients who responded to the survey, 273 patients would recommend the practice. We also reviewed the results of the national GP Patient Survey. Of the 268 surveys sent to patients, 115 surveys had been returned and completed. Of those 88% reported the last GP they saw or spoke with was good at treating them with care and concern, 79% reported the GP was good at involving them in decisions about their care and 91% reported the receptionist were helpful. All these were above the local Clinical Commissioning Group (CCG) average. However 51% reported it easy to get through on the telephone and 74% reported they were able to get an appointment to see or speak to someone the last time they tried. These were both below the local CCG average. We discussed this with the practice manager who was able to evidence the actions the practice had put in place to improve and monitor these services.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We received 15 completed cards. A majority of these cards contained detailed positive comments and stated that patients felt the practice was excellent. Patients were grateful for the caring attitude of the staff and for the treatment they had received at the practice. Three cards raised concerns about appointment availability.

Staff were careful to follow the practice confidentiality policy when discussing patients' treatment in order that confidential information was kept private. We saw this was respected at all times when staff were delivering care, in staff discussions with people and those close to them, and in written records. Facilities were available for patients to speak confidentially to clinical and non-clinical staff.

There were systems in place to support patients and those close to them to receive emotional support from suitably trained staff when required (particularly near the end of a person's life and during bereavement). Bereaved family members were offered the opportunity to speak with the GP or nurse whenever they wanted. There was information available at the practice to signpost the patient and those close to them to support groups. Patients we spoke with told us they felt supported by the practice. A record of patients who had recently died was in place to ensure that inappropriate correspondence was not sent.

The practice offered all patients the opportunity to be accompanied via a chaperone during their consultation.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour they would raise these with the GPs or the practice manager. Staff were able to give us examples of how incidents and learning outcomes had been discussed with staff, the managers and the partners.

Care planning and involvement in decisions about care and treatment

Staff involved patients in decisions about their care and treatment. The clinical staff we spoke with told us that they provided information to support patients to make decisions about their care and treatment. This included giving patients the time they needed to ensure they understood the care and treatment they required. The patients we spoke with and the comments cards we received confirmed this and patients told us that their views were listened to.

Patients we spoke to 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.

Good

Are services caring?

The practice provided a hearing loop and some members of staff had received sign language training and were prepared to assist patients with hearing impairment. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website also signposted people to 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.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Patients experiencing poor mental health received treatment, care and support at the practice and in the community when they needed it. The practice held a register of its patients known to have poor mental health and had effective procedures for undertaking routine mental health assessments. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. Patients with poor mental health were invited to attend an annual health review. The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.

The practice recognised that some vulnerable patients may find it difficult to attend the practice for care and support. The practice offered telephone consultations and contact via email, for patients that found it difficult for whatever reason to attend the surgery.

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 people's 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.

The practice adopted the Gold Standards Framework for the treatment of people nearing the end of their lives and requiring palliative care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. There were a range of services and clinics available to support and meet the needs of different patient groups. We saw that patients were referred to community specialists or clinics where appropriate. The practice worked closely with the community nursing team to support vulnerable patients with long term conditions. We saw the practice liaised with local midwives and health visitors for mothers, babies and young children.

The diabetic specialist nurse held clinics at the practice as patients' needs required. There was a community cancer matron attached to the practice. This was a pilot scheme which enabled the community cancer matron to work closely with patients who had been diagnosed with cancer, to provide them with care and support as they required. The practice worked closely with the community matron, whose role was to work with patients in the community to provide, plan and organise their care. The practice provided a carer support worker who held weekly clinics at the practice to offer advice and support to carers; the support worker also visited patients and their carers in their homes if they were unable to attend the surgery.

The practice employed a mental health counsellor who held weekly clinics at the practice for patients who may be experiencing poor mental health. There was also evidence of working closely with local organisations by offering the use of facilities within the practice to see patients who may not otherwise have the opportunity to be seen locally. For example the diabetic eye screening team and the occupational health team.

Patients we spoke with told us they felt the practice was responsive to their individual needs. The practice advanced nurse practitioner undertook weekly 'ward rounds' to proactively manage and co-ordinate care for patients in two care homes under the practice's care. There was an awareness amongst the staff team that the local population were striving to maintain independent living, either alone or with elderly partners. Patients we spoke with told us they had been visited at home when appropriate and felt confident the practice would meet their needs.

The practice was aware of patients access needs and had measures in place to support them. Treatment and consultation rooms were easily accessible on all floors via the lift. There were toilet facilities for disabled patients and baby changing facilities and access for wheelchair users. A self-check-in system was available in the reception in several different languages. The practice offered a range of appointments to accommodate the working population. These included telephone consultations, internet access for patients who may need to book appointments and request their prescriptions on-line. There was a text reminder service available for patients to remind them when their appointment was due; this also offered patients the ability to cancel their appointment should they need to.

The practice had systems in place to seek and act on feedback from patients. There was a suggestions and comments box available for patient's feedback in the waiting room area of the practice. The practice had an active patient participation group (PPG) to help it to engage with a cross-section of the practice population and obtain patient views. This consisted of 105 virtual members and 8 members who attended regular meetings at the practice. There was evidence of quarterly meetings with the PPG throughout the year. The practice manager and chair of the PPG produced both a Summer and Winter newsletter for patients registered at the practice. This highlighted recent PPG activity, changes to the service such as staffing, concerns raised and responses and results and action plans from the patient surveys. The practice had implemented suggestions for improvements and made

Good

Are services responsive to people's needs?

(for example, to feedback?)

changes to the way it delivered services as a consequence of feedback from the PPG. For example, improved signage for the nursing department and improvements to the practice telephone system.

The practice had been accredited as a GP training practice, as a suitable teaching centre for trainee GPs.

Tackling inequity and promoting equality

The practice was accessible for any vulnerable group. The staff culture evidenced that patients could access the practice's services without fear of prejudice.

The practice had identified patients with learning disabilities. These patients had individual care plans. People with learning disabilities were offered appointments that suited their working hours.

Staff were prepared to assist patients with hearing and visual impairment, or whose first language was not English in filling in any forms or accessing healthcare if necessary. The practice provided access to an interpreter to enable a good service to deaf or non-English speaking patients. The practice also had a hearing loop and some staff had attended a basic sign language course to assist patients with hearing impairments. GP names were displayed on consulting room doors.

The practice offered telephone consultations and contact via email for advice and reminders for those patients that found it difficult for whatever reason to attend the surgery. There was a booking in touch screen in the reception area with a variety of languages available.

Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was discussed at staff meetings.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays. 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 generally 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 clinician 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

The premises were purpose built and services were adapted to meet the needs of people with disabilities. The reception area, doors and corridors to clinical rooms within the building offered wide access to patients using wheelchairs and mothers with pushchairs.

The practice was situated on three floors of the building with the majority of services for patients on the first floor. Lift access was provided to all floors. We saw that the receptions and waiting room areas were all large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

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

The practice had taken steps to ensure patients were aware of the complaints procedure. Information on how to raise a complaint or concern was clearly displayed within the practice, in the practice leaflet and information was also available on the practice website. The process included timescales in which the practice would respond and information of other regulatory bodies to whom patients could complain. Staff told us that if someone wanted to make a complaint, the receptionist would see if there was anything they could help with, or patients could speak with or see the practice manager.

We saw the practice's log and annual review of complaints it had received. The review recorded the outcome of each complaint and identified where learning from the event had been shared with staff.

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 undergone a huge change in GP personnel in past 12-18 months and despite recruitment remained two whole time equivalent GPs short. The practice manager told us how the practice team had pulled together with the support from other local practices and the local NHS England team. However due to the shortage the practice had to close its list to new patients. We were told the practice remained very busy and this had impacted on staff over recent months with a larger than usual staff turnover. There were clear plans in place to minimise the risks with recruitment of clinical, non-clinical and nursing staff to support the GPs. For example an advanced nurse practitioner and health care specialists. The practice manager told us that GP recruitment was on-going and the practice planned to reopen its list to new patients in January 2015.

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We spoke with ten members of staff and they all knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these. Staff told us they felt there was an open door culture and that the GPs and practice manager were approachable. During our inspection we saw that staff were comfortable seeking advice and support from the GPs and nursing team.

Governance arrangements

There were systems in place to manage governance of the practice. The practice had structured

meetings that ensured information was shared, for example, GPs held weekly meetings to discuss clinical issues. GP partners, the practice manager and the finance manager met to discuss matters relating to the running of the practice such as staffing, significant events and complaints. This ensured that matters that may have an impact on patient care and safety were discussed to ensure awareness and effective service delivery.

There were clearly identified lead roles for areas such as medicines management, complaints and safeguarding.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at twenty of these policies and procedures. All the policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice had completed a number of clinical audits, for example prescribing and referral pathways.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as health and safety and fire risk assessments, legionella and infection control. 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 the practice regularly reviewed the risks associated with staff capacity and skill mix and had put plans in place to mitigate risks to patient care.

Leadership, openness and transparency

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 and 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. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. 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. We also noted that staff time to learn training afternoons were held every three months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and equality and diversity which were in place to support staff. We were shown the

Are services well-led?

Good

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

staff handbook that was available to all staff, these included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

Patients were encouraged to feedback their views. Information was provided on the practice website and in the practice leaflet inviting patients to put their comments in writing to the practice manager. There was a suggestion box in the waiting area. Following the practice 2013 to 2014 patient survey the practice had put in place a comprehensive action plan to respond to issues raised from the results. We saw details of actions completed. These included an action plan to encourage patients to notify the practice of their change of contact details and improved signage for the nursing area of the practice. Education events had been put in place to promote issues such as the community advocate service and diabetes. Information on the self-booking in screen now included information advising patients when they arrived of how long they would have to wait for their appointment. The practice had also made improvements to the layout of the reception area by removing a second set of internal doors to improve access for mothers with pushchairs and people using wheelchairs.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

Staff were aware of how to raise suggestions and concerns. The practice had a whistle blowing policy which was available to all staff in the staff handbook. Staff told us they felt confident they could raise a concern and felt their comments would be listened to. We were told by staff that they were encouraged to attend and participate in staff meetings. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at nine staff files and saw that appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training afternoons or protected time to learn (TTL) where training took place.

We saw evidence that learning from significant events, complaints and other incidents took place and appropriate changes were implemented. We saw that there were systems in place for the practice to audit and review significant events and complaints and that action plans were put in place to help to prevent them occurring again.