# Avenue Surgery Partnership

## Quality Report

14-16 The Avenue
Warminster
Wiltshire
BA12 9AA
Tel: Tel: 01985 224600
Website: www.avenuesurgery.co.uk

Date of inspection visit: 2 March 2015
Date of publication: 09/07/2015

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Avenue Surgery Partnership (Avenue Road Surgery) on 2 March 2015. Overall the practice is rated as Good. We found the practice to be good for safe, effective, caring, responsive and well led services for all of the population groups.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Overall risks to patients were assessed and generally well-managed, with the main exception of those risks relating to infection control.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Data showed patient outcomes were generally above or equal to the average for the locality. Although some audits had been carried out in 2014, data was not yet available to demonstrate that audits were driving improvement in performance to improve patient outcomes.
- Patients said their GP treated them with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and overall staff felt supported by management. The practice proactively sought feedback from staff and patients, which it had started to act on.
- The practice was involved in the productive GP Practice programme to improve patient services and practice efficiency.

# Summary of findings

- The practice was a research practice and participated in a number of research studies which had a potential impact on patient outcomes.
- Urgent appointments were usually available on the day they were requested. However, patients said that they sometimes had to wait up to two weeks for non-urgent appointments. In addition access to the practice via telephone was difficult.
- Infection control practice was not consistently followed in line with national guidance or practice policy.
- The practice employed a nurse specifically to assess, monitor and support patients over 75 years of age including assessments for frailty.
- GPs met with care home staff every two months to share best practice and training. Speakers were invited and topics covered a range of topics such as palliative care and medicines management.

We saw several areas of outstanding practice including:

- GPs had for a number of years recorded health education interviews for a local radio station. The topics covered included suggestions from the public and national public health initiatives.
- There were over 680 (4%) carers on the carers register and a designated member of staff to enable carers to be supported. The staff member had appeared on local radio to talk about the support that was available which included specific information and advice for carers and health reviews.

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

The provider should:

- Undertake a risk assessment regarding the location of emergency equipment.
- Continue to develop and review patient access for making and securing appointments.
- Ensure staff understand their role and responsibilities with regards to infection prevention and control requirements.
- Review patient group direction (PGD) records to ensure they do not include out of date PGDs.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Overall, lessons were learned and communicated widely to support improvement. Although risks to patients who used services were assessed, some of the systems and processes to address these risks required a review to ensure patients and staff were kept safe. For example, infection control processes and patient group directions.

**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 Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. The practice had introduced a number of initiatives to improve patients' outcomes. They employed a research practice nurse, and worked with local radio to promote health education advice. They had employed a nurse practitioner specifically for the assessment, monitoring and support of patients over the age of 75 years. The practice had a dedicated member of staff to enable carers to be supported.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated their overall experience of the practice as satisfactory although there were mixed comments about access to appointments. Patients told us staff were helpful and caring. They said staff treated them with dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff communicated with patients with kindness and respect, and maintained confidentiality.

# Summary of findings

**Are services responsive to people's needs?**

Good

The practice is rated as good for being responsive to people's needs. The practice had reviewed the needs of its local population, and had begun address the issues. For example, increasing nurse staffing levels to improve access to appointments.

We were told urgent consultations with the nurse and GP were available on the same day. However, patients still had waits of up to two weeks for a routine appointment with any GP. We were told by patients it was difficult to get through to the practice by telephone to make an appointment although patients could book via the practice website up to a year in advance. Evidence provided by the practice demonstrated 91% of telephone calls were answered within seven seconds once a call was put through although there were delays at certain times of the day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised.

**Are services well-led?**

Good

The practice is rated as good for being well-led. The practice was aware of the challenges to the practice and was proactive in their management. It had a clear vision and strategy. There was a clear leadership structure and staff generally felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Overall, with the main exception of infection control there were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it had begun to act on. The patient participation group (PPG) was active and motivated to support the practice. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice was a training and research 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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice employed a nurse specifically to assess, monitor and support patients over 75 years of age including assessments for frailty.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with the Clinical Commissioning Group average for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the care of working people. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

# Summary of findings

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. It had carried out annual health checks and had longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Quality Standards data (QOF) indicated 80% of people experiencing poor mental health had a plan of care. Information (QOF) demonstrated the practice was above the CCG average for monitoring the effects of medicines on patients' health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations including MIND. Some staff had received training on assessing and supporting patients with dementia

# Summary of findings

## What people who use the service say

On the day of the inspection we spoke with eight patients three of whom were from the patient participation group. We looked at 11 CQC patient comment cards, the GP National Patient Survey 2014/15 (published January 2015), the NHS choices website and the practice Friends and Family test results for 2015.

Patients we spoke with, patient comments cards and survey feedback we looked at demonstrated patients had mixed responses to the care and treatment they received. Patient feedback on the day described staff as helpful, caring and understanding. This was supported by feedback from the GP National Patient Survey 2014/15 which indicated 79% of the practice respondents said the last GP treated them with care and concern. Additionally 82% of respondents described their experience of the practice as fairly good or very good. Further information from the practice Friends and Family Test questions (January 2015) indicated 91% of 322 patients said they were extremely likely or likely to recommend the practice to family and friends. This was an improvement on results from the GP National Patient Survey 2014/2015.

Additional feedback on the day indicated patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. Feedback from the GP National Patient Survey 2014/15 indicated 76% of patients said the last GP they saw was good at involving them in care decisions which is comparable to the Wiltshire Clinical Commissioning Group average. However, only 57% of respondents in the GP National Patient Survey said nurses were good at involving them in care decisions which was below the CCG average of 68%. Patients felt their privacy and dignity were respected. They commented on the internal and external refurbishments to the practice and the improvements that this had made such as new chairs in the waiting area which improved the overall experience.

Most negative comments from patient feedback concerned the challenges of making a routine appointment and getting through to the practice by telephone. This was not wholly supported by data from the GP National Patient Survey 2014/2015 which indicated 60% of respondents said their experience of making an appointment was good or very good with additional information identifying 85% of patients saying their last appointment was convenient or fairly convenient.

However, patients requesting to see a GP for a routine appointment told us they often waited up to two weeks for an appointment. Some patient feedback on the day was sympathetic and suggested patients thought the difficulties of getting an appointment were a nationwide problem and not specific to the practice.

Patients indicated it was difficult to get through to the practice by telephone to make an urgent appointment particularly when the practice first opened in the mornings. This was supported by information from the GP National Patient Survey 2014/2015 where 34% of respondents found it fairly easy to get through by telephone and 59% not very easy or not easy at all. One patient told us they had come to the practice because they could not get through by telephone and was told to go home and wait for the GP to telephone them to assess their needs. Patients told us they appreciated they were able to book online appointments up to a year in advance which helped with planning work commitments.

Patients we spoke with were aware of the complaint process and generally expressed confidence in the practice to address concerns when they were raised. There were 34 written and verbal complaints from March 2014 to December 2015 addressing a range of issues.

## Areas for improvement

**Action the service SHOULD take to improve**
**Action the provider SHOULD take to improve:**

- Undertake a risk assessment regarding the location of emergency equipment.

# Summary of findings

- Continue to develop and review patient access for making and securing appointments.
- Ensure staff understand their role and responsibilities with regards to infection prevention and control requirements.
- Review patient group direction (PGD) records to ensure they do not include out of date PGDs.

## Outstanding practice

- GPs had for a number of years recorded health education interviews for a local radio station. The topics covered included suggestions from the public and national public health initiatives.
- There were over 680 carers on the carers register and a designated member of staff to enable carers to be supported. The staff member had appeared on local radio to talk about the support that was available which included specific information and advice for carers and health reviews.

# Avenue Surgery Partnership

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice nurse and practice manager specialist advisor.

## Background to Avenue Surgery Partnership

As part of the inspection we visited we visited the Avenue Surgery at 14-16 The Avenue, Warminster, Wiltshire, BA12 9AA.

The Avenue Surgery partnership provides primary care services to patients resident in Warminster. The provider has another practice in Warminster which is mostly used for administration purposes although it is the location for the practice's minor surgery service. The practice is a training practice for newly qualified doctors with a placement in general practice and a research practice involved in a number of research projects.

The practice is purpose built with patient services located on the ground floor and first floor of the building. The practice has an expanding patient population of 16,500 patients of which the highest proportion are of working age / recently retired. The practice has had a number of key staff changes during the last few years however the practice has addressed nursing shortages with the recent recruitment of a nurse and four health care assistants.

The practice has a total of five female and three male GP full time partners. There are six nurses, eight health care assistants, a practice manager, a deputy practice manager, and reception/administration staff.

The practice is open 8.00 to 6.30pm on Monday to Friday. The telephone service is open from 8.30 am to 1pm and 2pm to 6.30pm. Patients contacting the surgery before 8am or during the lunch closure are directed to reception for further advice if they considered they required urgent care. The practice operates extended hours for routine appointments from 7.30am on Wednesdays and Fridays and later appointments from 6.30pm to 8pm on Tuesdays and Thursdays. The practice has opted out of the Out of Hours primary care provision and this is provided by another provider MEDVIVO.

## Why we carried out this inspection

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.

## 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?

# Detailed findings

- 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 our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the Wiltshire Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 2nd March 2015. During the inspection we spoke with six GPs, the practice manager, six nursing staff, administration and reception staff. We spoke with eight patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at those practice documents that were available such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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 a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events and complaints were reviewed at quarterly dedicated meetings attended by the GPs and practice/deputy practice manager. In addition issues requiring urgent attention were discussed at the weekly partners meetings We were told other staff were not routinely invited to the meetings where action and learning took place. However, there was evidence that the practice had learned from significant event reviews and that the findings were shared with relevant staff for example, through team meetings and the quarterly staff meeting. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings.

National patient safety alerts were disseminated by the practice manager via email to practice staff. They included a mandatory email receipt to ensure they had been read. Staff we spoke with were clear about the process for accessing notifications that were relevant to the care they were responsible for. They also told us alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that 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 and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. We saw evidence there was regular contact between practice staff and the safeguarding lead with regards to advice and information regarding safeguarding concerns.

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. We looked at one example of a patient electronic safeguarding record as minutes of the monthly safeguarding meeting with the health visitors were not kept but recorded directly into the patient record. The record viewed confirmed notes were well documented and managed in a timely manner.

There was a chaperone policy. Patient advice regarding access to a chaperone was available in patient areas. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All staff with chaperone duties and staff assisting with children's immunisation clinics had training and the appropriate security checks via the Disclosure and Barring Service.

**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.

Good

# Are services safe?

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.

The prescribing lead GP told us prescribing practice was reviewed monthly and information from the Clinical Commissioning Group (CCG) and quarterly statistics circulated to GPs and nurse prescribers. We were given an example of how prescribing data demonstrated a specific prescribed medicine for pain management was above the CCG average. A strategy was in place for GPs to prescribe an alternative medicine and data (Medicines Management Scorecard 2014/2015) demonstrated an improvement in prescribing practice. Data 2013/2014 demonstrated patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were in line with CCG and national averages (CQC location data pack).

Nurses had access to up to date patient group directions (Patient group directions (PGD) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) which had been produced in line with national guidance. However, we identified PGD records required review as they included some out of date directions which may have caused some confusion for staff. The health care assistants administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber (PSDs are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis). Nurses and the health care assistants told us they had received appropriate training to administer vaccines. A number of the nursing staff were qualified as independent prescribers and received regular support from the GPs and attended updates in line with professional practice guidance.

There was a protocol for ensuring that medicines were kept at the required temperatures, Staff we spoke with were aware of the appropriate action to take in the event of a potential failure although this was not described in the protocol as on going guidance for staff.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Most prescriptions were issued electronically. Blank prescription forms were handled in accordance with national guidance following a recent incident at the practice. Overall the repeat prescribing procedure was efficient. Only GPs were able to initiate a repeat prescription (not nurse prescribers) and there was a specified time period before a further repeat was issued. The electronic records system did not allow repeat prescriptions to be issued if a patient required a medicines review or monitoring without GP approval. The data management team identified those patients requiring a medicines review on a monthly basis and identified patients overdue for a review with an alert for the relevant GP. GPs operated a buddy system to cover for sickness and holidays to enable patient monitoring and reviews to remain up to date.

There was a system in place for the management of high risk medicines such as methotrexate (for arthritis) and warfarin (blood thinning), which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they found the practice clean and we noted there had recently been refurbishments to improve cleaning and infection control measures such as replacement of chairs in patient areas which were wipe clean.

The practice had a GP lead for infection control. We saw two infection control audits had been completed by the deputy practice manager within the previous 18 months

although the frequency was not in line with the practice protocol and did not include hand washing audits. We noted there was not an action plan for the most recent audit and the audit had not identified some issues such as some clinical waste box labels not been fully completed in line with national regulations. Skirting boards in the treatment rooms were not coved to the walls to assist with cleaning. Nursing staff we spoke with were not aware that infection control audits had been undertaken. Evidence demonstrated staff received induction training about infection control specific to their role and received regular training updates.

Staff had access to personal protective equipment including disposable gloves, aprons and coverings. There was an infection control procedure which included a needle stick injury protocol to follow in the event of an injury. Staff we asked were aware of the immediate action to take in the event of an injury however, they were not confident about how to access further support from occupational health and the information was not available in the needle stick injury protocol.

There was a protocol for ensuring that medicines were kept at the required temperatures, Staff we spoke with were aware of the appropriate action to take in the event of a potential failure although this was not described in the protocol as on going guidance for staff.

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

**Equipment**

Staff we spoke with told us they had 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.

**Staffing and recruitment**

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

The practice had a number of key staff changes during the last few years. At the time of the inspection the practice had the full complement of eight fulltime GP partners. They had addressed nursing and healthcare vacancies with the recent recruitment of a nurse and four health care assistants. There were two nurses and one healthcare vacancy which had been advertised. In addition some nurses were undertaking additional training to enable them to develop their role such as nurse prescribing and diabetes training. There was a plan addressing anticipated GP vacancies due to retirement. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty to meet patients' needs. Nursing and administrative staff covered each other's annual leave. The GPs operated a buddy system or occasionally used locum staff to cover holidays or sickness.

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 and responding to risk**

Overall, the practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice with the main exception being infection control procedures. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We were told risks were discussed at GP partners' meetings and within team meetings.

**Arrangements to deal with emergencies and major incidents**

Good

# Are services safe?

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. However, we identified staff did not have access to emergency equipment if they were working upstairs in the practice although they were able to summon help readily. There was no evidence shown to us that a risk assessment to evaluate the risk to patients had been carried out.

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

A business continuity plan was in place to deal with a range of emergencies that may have impacted on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had records to demonstrate there had been a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could 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. We saw minutes of practice meetings where national guidance was discussed for example, immunisation protocols. The implications for the practice's performance and patients were discussed and required actions agreed. 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. For example, the use of templates, care pathways and care plans for patients with long term conditions such as respiratory disease. The practice had secured finances to employ a nurse practitioner dedicated to assessing and supporting patients over the age of 75 years of age. The funding proposal recognised the increase in patients with multiple medical conditions, the number of patients who were housebound in the locality and the importance of multidisciplinary working. The aim of the role was to reducing unnecessary medical interventions avoid unnecessary hospital admissions and enable timely advance care planning (advance care planning is the discussion and record of a patient's wishes for care at end of life).

The role included assessment of patient need including frailty (frailty is not a disease but a combination of the aging process and existing medical conditions), on going monitoring and review and multidisciplinary working to enable a holistic approach. At the time of the inspection the practice had not evaluated the impact of the role on patient outcomes as it was too early. However, there were clear performance indicators to evaluate the effectiveness of the role.

The practice used a risk stratification tool to identify 2% of the most vulnerable patients on the practice list. All of these patients had a personalised care plan to assist in their support and treatment to avoid admission to hospital. For those people with the most complex needs living at home, the named GP worked with a care co-ordinator who liaised with relevant health and care professionals to deliver a multidisciplinary package of care based on a person centred care plan.

We saw all patients (180) in the five care homes supported by the practice had a named GP and a personalised admission avoidance care plan which was reviewed every three months by their GP and care home staff to. Between 2014 and 2015 we saw evidence demonstrating there had been a 30% reduction in hospital admissions.

The practice had commenced an early dementia screening programme which included identifying patients at risk, undertaking combined nurse and GP assessment with patient consent and planned follow ups to review results and monitor treatment and support plans. Longer appointments and home visits were available for patients with dementia when needed.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancer. Additional data demonstrated the practice was in line with the Clinical Commissioning Group (CCG) prescribing performance.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

**Management, monitoring and improving outcomes for people**

The practice implemented a range of strategies to monitor and improve outcomes for patients. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us five clinical audits that had been undertaken in 2014 as part of the practice clinical audit programme. At the time of the inspection there was one completed audit where the practice was able to

Good

# Are services effective?

## (for example, treatment is effective)

demonstrate the changes resulting since the initial audit. The aim of the audit was to ensure the practice procedures on the prescribing and monitoring of lithium were being followed. The audit was repeated every six months and included a review of accuracy of record keeping, accuracy of monitoring of patients and patient information provided. The initial audit in October 2013 identified a number of aspects which could have been improved for example, the recording that patients had a lithium information and recording booklet and alert card (known as the purple book) in line with national guidance. The data from the audit demonstrated in October 2013 approximately 30% of patients had it recorded they had a 'purple book' compared to the audit in October 2014 which demonstrated an increase to just below 80%. In addition monitoring of patients living in the care homes required further work. The practice developed a patient pathway as information for staff in the care homes and included a reminder for practice staff regarding the schedule for monitoring patients living in care homes. We were told by the practice this had gradually improved care home concordance with the requirements of monitoring patients prescribed lithium. As a result of the audit the practice were in the process of developing similar pathways for use with care homes for other medicines such as warfarin (blood thinning).

Other examples of audits included a review of the monitoring of women prescribed the contraceptive pill (June 2014) to check whether they were monitored appropriately to reduce their risk of complications, the effectiveness of recording patients' cervical smear results (September 2014) and the accuracy of dementia electronic coding (February 2015). The audit schedule demonstrated the audits were to be repeated to demonstrate impact on patient outcomes in June and July 2015.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The QOF data (2013/2014) for the practice demonstrated the performance was above or equal to the local and national averages in almost all areas. For example, 97.4% of patients with chronic obstructive pulmonary disease (lung disease) had an annual medication review, and the practice met all the minimum standards for QOF in the management of long term conditions. This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice data team sent the GPs information each month identifying patients who required a review followed by a reminder if it was not undertaken. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the Gold Standards Framework for end of life care. It had a palliative care register and held monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. We looked at one example of a patient electronic record who was receiving palliative care. This was because meeting minutes were not kept but recorded directly into the patient's record. The record viewed confirmed notes were well documented and managed in a timely manner.

One GP delivered acupuncture sessions for patients both from the practice and from other GP practicein the locality. The number of sessions varied between four and six and although not formally evaluated we were told one patient had reduced their dependence on certain medicines used to treat a long term debilitating condition.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Because the practice was a research practice they had participated in a number of research projects locally, nationally and internationally and employed their own research nurse. Studies were of two types industry drug trials, and trials as part of the primary care research network. These studies tended to look at illnesses in primary care, for example urinary tract infections in women, coughs in children's, sore throats etc. All GPs and nurses involved in the research were GPC trained (Good Clinical Practice training ensures GPs are appropriately trained and experienced to carry out their research responsibilities). Patients from the practice were invited to

Good

# Are services effective?

## (for example, treatment is effective)

attend in a number of ways which includes mail outs, computerised searches and opportunistically during NHS appointments. The main aims of the research were to improve patient outcomes and practice. The practice gave us the findings of two research projects. One project required the GPs to participate in a survey to identify their prescribing practice of pain medicines for non -cancer pain. Patients from the practice prescribed the medicines were also contacted with their consent to explore how they used the medicines prescribed. The final part of the project the GPs involved in the attended education sessions regarding the prescribing of opiates. The results of the study demonstrated an increase in GP knowledge about prescribing opiates at the end of the training.

The patient participation group had set up a prostate cancer group for patients in the practice. Letters were sent out by the practice inviting patients having been diagnosed with cancer to attend the support group. The aim of the patient led group was to provide support and information.

Patients experiencing poor mental health had access to local psychological services. Quality Standards data (QOF) indicated 80% of people experiencing poor mental health had a plan of care. Information (QOF) demonstrated the practice was above the CCG average for monitoring the effects of medicines on patients' health.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We found the practice staff training records were generally well maintained particularly with regard to staffs continuing professional development education and training. Information regarding mandatory training was also recorded but needed more details for example, specific dates of attendance and levels of training. The records we looked at demonstrated that staff had attended mandatory training such as basic life support, information governance, health and safety and fire training and infection control updates. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles such as respiratory assessments were also able to demonstrate that they had appropriate training to fulfil these roles.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. In addition the practice had started one to one supervisions for staff to discuss on going concerns. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example independent prescribing and diabetic course. We saw there were monthly education sessions for GPs and nurses. As the practice was a training practice, patients were offered extended appointments and doctors had access to a senior GP throughout the day for support.

We reviewed evidence that showed that where poor performance had been identified appropriate action had been taken to manage this.

**Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. 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.

The practice was commissioned for an enhanced service to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that weekly meetings took place with members of the multidisciplinary team to review admissions and discharges from hospital. The practice held additional 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 district nurses, palliative care nurses and health visitors. Decisions about care planning were documented in a shared care record.

Meetings also took place with care home staff every two months to share best practice and training. Speakers were invited and topics covered a range of topics such as palliative care and medicines management.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational in 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

We found GPs and nurses applied the principles of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 to their practice area. We saw staff had a practice awareness session on the Mental Capacity Act 2005 particularly with regards to safeguarding vulnerable adults and had completed on line training safeguarding vulnerable adults training which included information about consent, Deprivation of Liberties Safeguards and mental capacity.

Staff we spoke with gave examples of how they supported patients with diminished capacity to understand and make decisions about treatment. They understood the meaning of patient consent when asked and how consent could be given. Strategies included allowing patients time, checking understanding by asking patients to repeat back their understanding of the treatment they were to receive. Nurses told us they involved carers with the patient's permission when making decisions about treatment in the patient's best interests if a patient did not have capacity to make a decision.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing.

Overall staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions) and a duty of confidentiality to children and young adults.

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

**Health promotion and prevention**

The practice had a range of approaches to enable patients to take responsibility for their own health when they were able. We saw there was health promotion information in the practice for all age groups. Practice GPs had for over eight years recorded health education programmes for a local radio station. The topics covered included suggestions from the public and information relating to public health campaigns. There were approximately 20 pre-recorded interviews which were played every Saturday morning. The practice told us evaluation of the programmes were informal however, they had recently been nominated for a broadcasting award and were waiting for the results. In addition patients continued to ring in with suggestions for the broadcasts.

Young adults had access to free screening kits for chlamydia (a sexually transmitted disease) which were

available for under 25's, emergency contraception and access to free confidential sexual health advice for under 19's whether registered with the practice or not.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients

Good

# Are services effective?

## (for example, treatment is effective)

registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had a number of ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and dementia. All patients with a learning disability were offered a health review with the practice nurse and GP.

The practice offered nurse-led, patient self-referral smoking cessation and weight management clinics for patients. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 73% (National Cancer Intelligence Network 2014), which was significantly lower than other practices in the CCG area and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

Performance for national mammography and bowel cancer screening in the area were all above average for the CCG (78.5% and 58% respectively. National Cancer Intelligence Network 2014). The practice were aware of the low uptake of bowel screening and had begun to address the issue, by involving the patient participation group in discussions as to how to raise patient awareness and using posters in addition to the health promotion material already in the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu and shingles vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG. For example, the percentage of children registered at the practice receiving immunisations at 12 months of age were: meningitis C were 98.6% (CCG average 98.1%), at 24 months of age measles, mumps and rubella were 94.8% (CCG average 95.7%) and at five years of age whooping cough were 96.8% (CCG average 96.9%)

Children who did not attend for immunisations were followed up.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

Although there were mixed comments about some of the services the practice provided generally patients we talked with spoke positively about the staff at the practice. We spoke with eight patients and looked at 11 completed CQC cards on the day of the inspection. Patient feedback on the day described staff as helpful, caring and understanding. They said staff treated them with dignity and respect. This was supported by feedback from the GP National Patient Survey 2014/15 which indicated 79% and 78% of the practice respondents said the last GP and nurse (respectively) they saw treated them with care and concern. Additionally 82% of respondents described their experience of the practice as fairly good or very good. Further information from the practice Friends and Family Test questions (January 2015) indicated 91% of 322 patients said they were extremely likely or likely to recommend the practice to family and friends. This was an improvement on results from the GP National Patient Survey 2014/2015.

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 rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

**Care planning and involvement in decisions about care and treatment**

Patient feedback demonstrated generally patients were involved in decision making and consent was sought for treatment. The GP National Patient survey (2014/2015) indicated 76% and 57% of patients felt GPs and nurses involved them in decision making (respectively). Additional information indicated 81% and 66% patients thought GPs and nurses were good at explaining treatment (respectively). The results for nurses were below the CCG average. We saw from minutes of a nurses' team meeting the results had been highlighted and there were discussions as to how staff could involve patients more in decisions about their care. Patients we spoke with agreed nurses and GPs asked their permission before undertaking treatment.

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**

Information from the GP National Patient Survey (2014/2015) indicated 71% of patients said they had most definitely or to some extent had enough support from local services and organisations. The practice referred patients for services including support at home via a single point of access. We saw from significant event information patient concerns about the service were addressed promptly.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. We noted there were no links to support organisations on the practice website. We were told the practice website was a practice development priority. The practice's computer system alerted GPs if a patient was also a carer. There were over 680 carers on the carers register and a designated member of staff to enable carers to be supported. The staff member had appeared on local radio to talk about the support that was available which included specific information and advice for carers and health reviews. The practice was participating in a locality GP carer's awards scheme and were working towards a silver award.

Staff told us that if families had suffered bereavement, their usual GP contacted them.

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 patient's needs and had improved systems to maintain the level of service provided. They were aware of how the challenges of a shortage of staff had impacted on accessing routine appointments and had responded by increasing the number of nursing staff. They had a new telephone system to improve telephone access to the practice. The practice manager had implemented suggestions from the patient representative group and patient survey. For example, refurbishments of the building which patients told us had improved their experience of the service.

The practice had an expanding patient population of which the highest proportion were of working age. In response to this the practice offered a flexible appointment system opening later two evenings a week and earlier for booked routine appointments for patients not able to attend during normal working hours. Patients were able to book online appointment up to a year in advance which helped them plan for work commitments. Prescriptions could be booked online and were available within 48 hours.

Patients had access to some specific investigations such as spirometry (for breathing), 24 hour blood pressure monitoring, electrocardiogram (ECG) monitoring and blood testing to assess blood clotting time for patients taking blood thinning medicines therefore reducing the need for hospital appointments. Patients with long term conditions had regular health reviews.

All patients had a named GP. In order to meet the increasing numbers of patients over 75 years of age they had employed a dedicated nurse practitioner to assess, monitor and support the frail older adult with multiple conditions.

The practice GPs were the designated GPs for patients holidaying at the local holiday park. We saw there was a procedure to enable efficient registration as a temporary resident and a system to review the process when issues with registration for this group of patients occurred.

Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. The practice was a breastfeeding friendly practice enabling mothers the freedom to breastfeed without the risk of missing their appointment if they ran late.

The practice offered a range of sexual health services for patients including the fitting of contraceptive coils (IUCD) and cervical smears. Young adults had access to free screening kits for chlamydia (a sexually transmitted disease) and these were available for under 25's and access to free confidential advice whether registered with the practice or not.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services.

The practice held registers of patients with learning disabilities, dementia and certain mental health conditions. Longer appointments for patients with learning disabilities were arranged in recognition of the time needed to involve patients in their care and treatment. QOF data (2014) indicated 87.8% of patients with dementia had a face to face review. Additional QOF data (2014) demonstrated the monitoring of patients experiencing mental health problems was in line with the CCG average.

Patient services were situated on the ground and first floor. There was a lift to the first floor. The waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. We saw the practice had responded to requests from patients and had purchased some higher seating with arms to enable patients to get out of the chairs more easily. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. We noted some of the toilet ware was colour contrasted to assist patients with dementia and visual impairment to locate the facilities more readily.

Practice staff met every two months with members of the multidisciplinary team (MDT) to support patients at end of life. A nurse co-ordinator employed by a local hospital and commissioned by the CCG worked with the practice to work with the GPs and MDT to develop care plans and monitor patient wellbeing to avoid unplanned admissions to hospital.

GPs supported patients living in five care homes to have access to practice services.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had access to telephone translation services for patients where English was not their first language.

**Access to the service**

We found the practice had made some changes to improve access to practice services although there were still mixed patient views about the adequacy of some service provision. The practice was open 8.00 to 6.30pm on Monday to Friday. The telephone service was open from 8.30 am to 1pm and 2pm to 6.30pm. Patients contacting the surgery before 8am or during the lunch closure were directed to reception for further advice if they considered they required urgent care.

The practice operated extended hours for routine appointments from 7.30am on Wednesdays and Fridays and later appointments from 6.30pm to 8pm on Tuesdays and Thursdays. However, the practice systems did not consistently facilitate easy access to appointments. Patients told us they were usually able to access on the day consultations with either the doctor or nurse.

All on the day urgent appointments were initially triaged by the receptionists following a set protocol of basic questions and then reviewed by the duty GP. If it seemed appropriate and with the patient's consent patients could be referred directly for an appointment with the minor illness nurses for example, with coughs, colds and rashes. We were told if the nurses had concerns or required further advice during the consultation the patient would be seen by a GP. If the patient requested a consultation with the GP the duty GP rang the patient to determine whether they required a telephone, a face to face consultation or a consultation with the nurse.

There were mixed views about access for routine appointments and contacting the practice via telephone. For example, of three comments on the NHS choices website two patients had indicated how satisfied they were with the practice with one commenting on the ease of getting through to the practice. However, the other comment was less complimentary identifying difficulties with getting through to the practice by telephone and also getting an appointment.

Patient comments and feedback looked at on the day was equally diverse. Of the 11 comment cards received three patients commented on the time taken to wait to get through to the practice and three patients commented on the length of time for a routine appointment. One patient told us they had attended the practice because they could not get through by telephone. They were told to go home and wait for the GP to telephone them to assess their need. The patient then had to return to the practice to see the GP. All comments cards and patient feedback included some positive feedback about the practice and staff.

Of the 34 complaints received by the practice five were specifically about the length of time to wait for a routine appointment. Data from the GP National Patient Survey 2014/2015 indicated 60% of respondents said their experience of making an appointment was good or very good with additional information identifying 85% of patients saying their last appointment was convenient or fairly convenient. Patient feedback indicated that to get a routine appointment with any GP took up to two weeks. On the day of the inspection (2 March 2015) the next available appointment was the 12 March 2015 (nine working days).

The practice had already implemented a number of strategies to alleviate the difficulties. For example, increasing the number of telephone lines and therefore the number of call that could be 'waiting' in the queue to be answered before an engaged tone. The telephone system now informed patients that all lines were busy advising to call back rather than a continuous ringing tone until answered. We saw practice data from December 2014 and January 2015 which demonstrated 91% of calls once they had reached the top of the queue were answered in seven seconds or less.

There was information in the practice leaflet to remind patients of the difficulty of getting through to the surgery during peak times advising them to try booking an online appointment or to avoid peak times.

We were told a shortage of nursing staff had resulted in GPs undertaking patient reviews which would have normally been undertaken by nursing staff. This resulted in reduced availability of GP appointments. To address the issue we saw a nurse and four healthcare assistants commenced at the practice between October 2014 and January 2015. Two further nurses and one healthcare vacancies had been advertised. In addition some nurses were undertaking additional training to enable them to develop their role such as nurse prescribing and diabetes training.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the practice leaflet and website.

Appointments were available outside of school hours for children and young people. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three care homes including 'weekly ward rounds' to all homes.

**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.

We saw that information was available to help patients understand the complaints system. Most patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with on the day of the inspection had ever needed to make a complaint about the practice.

The practice reviewed complaints regularly to detect themes or trends. 34 complaints were reported in 2014. We looked at the complaints and five concerned appointments and telephone access to the practice. The remaining complaints had no recurring themes. We noted from the complaints had been addressed appropriately. Complaints were discussed at the quarterly staff meetings and at the weekly partners meetings as well as at team meetings and with individuals concerned. We saw the practice manager had responded satisfactorily to comments made on the NHS website.

# 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 understanding of the strengths and areas of improvement required to improve services for the patients it supported. The improvements made such as an upgraded telephone system to enable better access to the practice and the recruitment of more nursing staff reflected the challenges the practice had encountered during the previous two years as a result of staff changes and difficulties.

The practice values emphasised a commitment to providing a high standard of care which was reflected in the attitudes of staff we spoke with.

**Governance arrangements**

The practice had a clear leadership structure with GPs taking lead roles in key areas for example infection control, safeguarding and information governance. The GPs operated a buddy system to cover for holidays/sickness to enable continuity of patient care. This seemed to work well.

The practice had progressed to a model of individual teams with oversight of the nursing team by the GPs and the administration teams by the practice manager There were a number of formal and informal opportunities to discuss governance issues. For example, the GPs met daily, informally to discuss practice or patient concerns. Practice issues and decision making took place at the weekly partners meetings with the practice manager and deputy practice manager. In addition there were quarterly meetings to address complaints and significant events and incidents. Individual teams usually met on a monthly basis. The practice manager met with team leaders from reception and administration to discuss the day to day issues of running of the practice. The practice manager/ deputy manager attended all team meetings and disseminated practice information and updates to the individual teams. We noted that the nurses had requested that a GP attend their meetings but that had yet be addressed. All meetings were minuted and we were able to see risks, performance and quality were discussed.

Staff we spoke with were clear about their own roles and responsibilities. They told us they enjoyed working at the practice and generally felt supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing 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.

There were five audits (2014) available for us to see on the day of the inspection. One audit regarding the monitoring of patients prescribed lithium a medicine prescribed for certain mental health conditions had completed a full audit cycle to demonstrate the effectiveness of the changes made.

The practice had a range of policies and procedures as guidance for staff. We looked at a range of policies and procedures and with the exception of those concerning infection control practice we found they were overall sufficiently detailed and were up to date. Staff knew how to access the policies and procedures.

**Leadership, openness and transparency**

Overall, there were systems in place to enable effective staff communication. The practice had a range of strategies to address staff communication. We saw from minutes that team meetings were held monthly and whole practice meetings every four months. The minutes and presentations from the team and staff meetings were available for staff if they were unable to attend. We noted information from the staff survey (2014) and one team minutes indicated staff felt practice communication could be improved. We were told and saw from meeting minutes the practice manager was the initial channel for communication if staff had queries or concerns. To enable the process staff had the option of regular one to one 'supervision' meetings with the practice manager. Staff told us they were able to raise issues at team meetings. There were three strategic away days for GPs and other staff depending on the issues to be discussed. Information from the away days was shared with staff at the whole practice meeting.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff.

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

# Are services well-led?

Good

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

The practice had regular feedback from patients which they had responded to. The practice gathered feedback from patients through a practice survey and an active patient participation group (PPG), complaints and significant events and incidents. We looked at the results of the practice patient survey 2013/2014 which had been undertaken with the PPG and saw the practice had responded to concerns. They had upgraded the internal and external decoration. There were chairs of an appropriate height and design to enable patients to get out of the chair more easily. The practice had a new telephone system to improve patient access to the practice. They had employed more nursing staff and introduced SMS texts to remind patients of their appointment to reduce non-attendance and release more appointments.

The practice had an active, motivated patient participation group (PPG) which had steadily increased in size. The PPG met every quarter with a representative from the practice. They told us overall communication between the practice was improving with excellent support from one of the GPs. There were examples of partnership working such as a successful flu campaign. Representatives from the PPG undertook practice walkabouts and provided feedback to the practice manager. They were involved in the Productive General Practice Programme. (The GP productive general practice programme is an initiative supported by NHS Improving Quality. The aim of the programme is to enable GP practices to improve their efficiency and effectiveness). The practice were implementing one of the first modules' Involving Patients in Improvement'. A committee of six staff members and six patient representatives were involved in exploring how patients could be better involved in practice decision making. Their first task was to review the findings of the most recent patient survey (2014/2015) and how these could be implemented.

The practice had undertaken a staff survey in 2014. The survey explored staff opinions about a range of topics. The results demonstrated that communication still required improvement. We did not see an action plan following on from the survey. However, we saw staff had one to one sessions with the practice manager as one way to enhance communication.

The practice had a whistleblowing policy which was available to all staff.

**Management lead through learning and improvement**

Evidence gathered throughout our inspection through staff interviews, records and policy reviews indicated overall management lead through learning. There were records of meeting minutes which would have acted as a resource for staff unable to attend the meetings. Although staff were involved in significant events, complaints and incidents, they did not generally participate in meetings where actions and learning took place although they had access to the meeting minutes. However, we were told specific events and complaints were presented at the whole practice meetings every four months as a means to learning and also at team meetings where relevant.

Results from clinical audits were shared at education meetings however, this did not include the infection control audit. Nursing staff we spoke with were not aware of the audit and findings and were not involved in the audit.

Nursing staff told us they were able to remain updated with mandatory training for example, basic life support and continuing professional development requirements such as diabetes training. We were told there were monthly education meetings for nurses, healthcare assistants and GPs as updates about clinical issues. We saw from team meeting minutes that one GP had delivered a teaching session on stress management for reception staff.

Staff had an annual appraisal. We were given an example of how a member of staff identified the need for a lead healthcare assistant. The practice advertised the role internally and a suitable applicant was appointed. We saw and staff confirmed that new staff were supported via an induction programme with specific support to orientate and train them for their role.

The practice was a research practice. The practice employed their own research nurse and participated in a range of local, national and international research projects. Patients from the practice were involved with their consent. Findings from the research projects were shared with staff at education meetings.

The practice was a training practice for newly qualified doctors with a placement in general practice.