Coalway Road Medical Practice

Quality Report

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Date of inspection visit: 27 May 2015
Date of publication: 16/07/2015

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Coalway Road Medical Practice on 27 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all 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.

• Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks as there were no written records in the files reviewed of the staff references obtained.

• 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.

• The majority of patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

• Patients said they found it easy to make an appointment with their named GP but not always with their preferred GP. Urgent appointments were available the same day.

• There was a clear leadership structure and staff felt supported by management.

• The practice had implemented a lunchtime children's clinic in order that parents could more readily attend for developmental checks and immunisations.

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

The provider should:

- Ensure all staff are aware of and can identify with the practice vision and values.
- Continue the development of a patient participation group.
- Consider improving entry access for disabled patients.

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- Formalise and strengthen some of the informal governance and leadership arrangements in place.
- Consider whole staff meetings to share any findings from incidents and significant events.
- Review the national GP patient survey data and consider further patients experiences of making appointments including phone access.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Recruitment records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment, with the exception of a written record of the staff references obtained. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice assured us that the business continuity plan would be addressed to ensure all risks were rated and measures put in place to reduce the risk.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with others in the CCG locality for several aspects of care. For example 93% of respondents to the national GP patient survey found that patients had confidence and trust in the last GP they saw or spoke to, and 83.7%had confidence and trust in the last nurse they saw or spoke to. Patients said they were treated with compassion, dignity and respect and the majority said they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they could make an appointment with a named GP but not always their preferred GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and the practice had awareness of areas within the practice that required improvement. It was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were unaware of the practice vision, values or strategy, so they could not identify with or be clear about the practice vision or their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular practice partner meetings which the practice manager also attended; these meetings included some elements of practice governance. The practice did not hold governance specific meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was in the process of being developed. Staff had received inductions, regular annual appraisals. A whole staff meeting did not take place. However the GP partners assured us during the inspection that they would start to hold regular meetings for all staff members.

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.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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. Immunisation rates were in line with the CCG average for most standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.The practice had implemented a lunchtime children's clinic in order that parents could more readily attend for developmental checks and immunisations.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered 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). Ninety four point eight percent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. The practice developed a protocol for a specific medicine which alerted staff on their electronic systems to ensure patients received appropriate monitoring and support which included shared care plans.

Summary of findings

What people who use the service say

We spoke with eight patients during the inspection and received19 completed Care Quality Commission (CQC) comments cards in total. The majority of the patients we spoke with said they were happy with the service they received overall.

The National GP patient survey 2015 results for this practice found that 86% said the last GP they saw or spoke to was good at giving them enough time and 82% said the last GP they saw or spoke to was good at listening to them. This was based on findings from the 104 surveys returned out of the 291 surveys sent out, giving a 36% completion rate. Seventy-seven percent said the last GP they saw or spoke to was good at explaining tests and treatments, 71% said the last GP they saw or spoke to was good at involving them in decisions about their care and 80% said the last GP they saw or spoke to was good at treating them with care and concern. Ninety three percent of those surveyed said they had confidence and trust in the last GP they saw or spoke to. The survey found that 61% of respondents found it easy to get through to the practice by phone, which was lower than the local Clinical Commissioning Group (CCG) average of 72%. The percentage of patients that would recommend their practice was 71% compared with the CCG average of 71.6% and 81% described their overall experience of this practice as good compared with the CCG average of 83.5%.

The surgery at the time of the inspection did not have an active Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice clearly demonstrated that they had begun to set up their PPG and advertise for membership.

Patients did not identify any problems specifically with confidentiality at the reception desk. Patients were aware they could ask to speak to the reception staff in another room if they wanted to speak in confidence.

Patients we spoke with told us they were aware of chaperones being available during examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GP, nurses and reception staff explained processes and procedures and were available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service SHOULD take to improve

Ensure all staff are aware of and can identify with the practice vision and values.

Continue the development of a patient participation group.

Consider improving entry access for disabled patients.

Formalise and strengthen some of the informal governance and leadership arrangements in place.

Consider whole staff meetings to share any findings from incidents and significant events.

Review the national GP patient survey data and consider further patients experiences of making appointments including phone access.

Coalway Road Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP, and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Coalway Road Medical Practice

Coalway Road Medical Practice is located on Coalway Road, Penn, Wolverhampton and is part of the NHS Wolverhampton Clinical Commissioning Group. The total practice patient population is 5,276. The practice is in an area considered as a fifth more deprived when compared nationally. People living in more deprived areas tend to have greater need for health services. The practice has a higher proportion of patients aged 65 years and above (33.6%) which was higher than the practice average across England (26.5%).

The staff team currently comprises two male GP partners and a female GP partner. The practice team includes a practice nurse and healthcare assistant, a practice manager, seven reception/administration staff, employed either full or part time hours with a part time vacancy for a reception/typist.

Coalway Road Medical Practice opening times are 8.30am to 6.30pm Monday to Friday with a late Clinic on Mondays. Should this fall on a bank holiday the late clinic date changes to Tuesday. A locum GP provides Thursday afternoon sessions at the practice this service is in addition to the out-of-hours provider, Primecare via the 111 service who take all incoming calls from Thursday afternoons until Friday morning. The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed through the 111 telephone service where telephone calls are directed to Primecare, the out-of-hours service.

The practice provides a number of clinics for example long-term condition management including asthma, diabetes and high blood pressure. It also offers child immunisations and travel health.

Coalway Road Medical Practice is an accredited GP training practice.

The practice has recently changed to a General Medical Services (GMS) contract with NHS England. They also provide some enhanced services, for example the Directed Enhanced Services – Childhood Vaccination and Immunisation Scheme. This aims to ensure that children in the practice area are able to benefit from the recommended immunisation courses and benefit from the recommended reinforcing doses. This is a contract for the practice to deliver general medical services to the local community or communities.

Detailed findings

Why we carried out this inspection

We carried out inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act

2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS Wolverhampton Clinical Commissioning Group, Healthwatch and NHS England Area Team. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We carried out an announced inspection on 27 May 2015. During our inspection we spoke with a range of staff including GPs, practice nurse, healthcare assistant, practice manager and reception staff. We observed how patients were communicated with and how the practice supported patients with health promotion literature. We reviewed 19 CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available to patients at Coalway Road Medical Practice location prior to the inspection.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. For example emergency medicines may have been required for a patient who had a seizure. The keys for the treatment room where the emergency drugs were held were with other keys and not readily identifiable. There was a risk of delay in obtaining the required medicine. The outcome was that the medicine in this specific case was not required. The practice however took action in response to this incident to appropriately label all keys to reduce the risk of delay. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last nine years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were not discussed as a standing item on the partner practice meeting agenda. However, we saw in the January 2015 minutes, for example, that a significant event had been discussed. The partner practice meeting included the practice manager but no other practice staff or GP trainees. There was no formalised dedicated meeting held to review actions from past significant events and complaints. There was evidence that the practice forwarded memorandums to staff of policies, procedures or changes to practice which were derived from learning or action points from any incidents, events, compliments or complaints. Staff spoken with confirmed this activity took place. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the partner meetings and they felt encouraged to do so, however they told us they only attended when invited to do so, for example if the partners felt information relevant to their role.

Staff used incident forms and these completed forms were sent to the practice manager. She showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared for example in the monitoring of fridge temperatures and record keeping. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated electronically to practice staff. Staff we spoke with gave examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed informally on a one to one basis, via memorandum and at the partner practice meetings, to ensure all staff were aware of any that were relevant to their 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 in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. 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.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to

child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard but not in the consulting rooms or on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff acted as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice had read code systems in place which allowed for the identification and follow up of children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers) but not for identifying children and young people with a high number of A&E attendances. The practice GPs attended child protection case conferences, reviews and Serious Case Reviews (SCR) where appropriate or a report sent if unable to attend. A serious case review (SCR) takes place after a serious incident or event takes place and looks at lessons that can help prevent similar incidents from happening in the future. The GPs and practice nurse informed us that they followed up on children who persistently failed to attend appointments for childhood immunisations with follow up letters, phone calls and referrals to the health visitor.

The practice electronic systems also identified older and vulnerable patients such as those living with dementia. We saw that the practice was supported by a weekly visit from a pharmacy advisor and had systems for reviewing repeat medications for patients with complex needs on multiple medicines

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. However we found that all the paper prescriptions were in the lead GP's name. The practice assured us that they would gain advice and guidance on this matter and action accordingly.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw for example in the practice partner meeting in February 2015 discussion took place on the use of dementia care and antihistamine medicines.

There was a system in place for the management of high risk medicines such as disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in 2015. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD in from the prescriber.

Good

Are services safe?

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to appear 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 appeared clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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 received annual updates. We saw evidence of annual audits and that any improvements identified for action were completed on time. Minutes of the partner practice meetings showed that the findings of the audits were discussed.

We found that there were wooden based examination couches in the consulting room which had washable cushioning. Changes to these couches were being planned for and the practice manager and nurse both informed us that this had been identified in the recent infection control audit.

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

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

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 which was February 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The majority of staff had been employed by the practice for more than five years. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment, with the exception of a written record of the staff references obtained. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a reception staff vacancy and we saw staff were encouraged to cover the position between them until a new staff member was appointed. The reception staff we spoke with were multi-skilled and were particularly busy on the phones and with patients in reception until 11am. One of the practice partners was also planning to retire and the practice had succession planning in place to recruit for this vacancy. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Good

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of medicines management, staffing, dealing with emergencies and equipment. We saw that the practice general risk assessment had identified a small number of areas to address which had included a regular written record of checks of the building and environment. We did not see a written record of these checks however the practice manager and GPs informed us this took place informally every day and assured us they would consider recording these informal checks. We saw evidence to demonstrate that the practice did review the building premises and environment in the practice partner meeting minutes for example the flooring in the practice toilets and baby change room in March 2015 and roof repairs in the April meeting. These remained on the agenda to be reviewed weekly until the action was complete. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk, however this had last been reviewed in August 2011. Risks associated with service and staffing changes (both planned and unplanned) were included on the log. We saw an example of this with the most recent staff vacancy and the mitigating actions that had been put in place.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. Emergency processes were in place for acute pregnancy complications. The practice monitored repeat prescribing for patients receiving medication for mental ill-health. The practice developed a protocol for a specific medicine which alerted staff on their electronic systems to ensure patients received appropriate monitoring and support which included shared care plans.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. We found that this was a work in progress, for example there was no identified alternative practice or premise location in the event of loss of premises, but there were contact numbers for the local Clinical Commissioning Group to inform them and enable a search for alternative locations, there was no information on the actions required by staff for example in respect of expectation on what vital records would need to be retrieved or how. The practice manager and GPs assured us that the business continuity plan would ensure that each risk was rated and mitigating actions recorded to reduce and manage the risk. We saw that the risks which had been identified included power failure, adverse weather and unplanned sickness. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in 2015.

The practice had carried out a fire risk assessment in 2015 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 clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of practice partner meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. We saw that the nurse and healthcare assistant did not attend these weekly meetings and that there were no whole team meetings held. Clinical staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as minor surgery and children's immunisations and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. We did not see evidence of specific clinical meeting minutes to further demonstrate that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice and GP trainees to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last 12 months and that on average the practice completed a minimum of three audits per year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence (NICE) guidance. The practice nurse also contacted patients a week following the procedure to check on wound progress.

Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an audit of stroke prevention therapy in patients with atrial fibrillation which had identified suboptimal prescribing and following the audit 98% of the patients were on optimal medicine regimes.

We saw that the practice had a repeat prescribing risk assessment tool in place which included risks associated with the production of a prescription such as hand written, computer generated and ensuring these are completed in a

Good

Are services effective?

(for example, treatment is effective)

timely manner as well as the authorisation and signature checks, as well as compliance checks for the medicines such as dosage, contraindications and side effects all of which were risk rated.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of a medicine commonly used in Osteoporosis and the consideration of treatment holidays from this medicine in August 2014. The National Osteoporosis Guideline Group (NOGG) produced guidance on the length of treatment use of this medicine but that patients at high risk of fracture should continue the treatment and not have a medicine holiday. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 90.1% of the total QOF target in 2014, which was slightly below the practice average across England of 94.2%. Specifically we found that:

• Performance for diabetes related indicators were similar to the national average.

• The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.

• Performance for mental health related and hypertension QOF indicators were similar to the national average.

The practice was aware of any areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed for example in the dementia diagnosis rates which had improved following a review of the coding onto their electronic systems.

The team was making use of clinical audit tools, and staff appraisals to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement, although we found there to be no expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

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

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. We saw for example that all of the 43 patients registered at the practice who were living with dementia had had an annual review. Structured annual reviews were also undertaken for patients with long term conditions (e.g. Diabetes, COPD, Heart failure).

The practice was able to evaluate their performance data and compare it to similar practices in the area. This benchmarking of data showed the practice had outcomes that were lower than some other services in the area. For example the Clinical Commissioning Group (CCG) reported that the practice had low accident and emergency attendance and low walk-in-centre activity for the two local walk in centres.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. 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

Good

Are services effective?

(for example, treatment is effective)

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. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example chaperone training, electronic prescribing and cervical screening. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Practice nurses and healthcare assistant told us they had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and diabetes care. Those with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. We did not see evidence in the staff files reviewed of a current job description which the practice manager assured us would be addressed. We found that the practice nurse and healthcare assistant carried out Electrocardiogram (ECG) monitoring which is equipment used to record the electrical activity of the heart to detect abnormal rhythms and the cause of chest pain. We noted that the ECG training was completed in 2006 and were informed by one of the GPs that the practice nurse had taught the healthcare assistant to undertake ECG monitoring following completed competency checks. There was no written information on any recent completed competency checks for the practice nurse or healthcare assistant.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs and practice staff had awareness of their responsibilities in passing on, reading and acting on any issues arising from these communications. Out-of-hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were noted as 21.6% compared to the national average of 13.6% between April 2013 and March 2014, which although higher than the national average was considered as similar to that expected. The practice held multidisciplinary team meetings at least three monthly to discuss patients with complex needs. For example, (those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register). These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record (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

Good

Are services effective?

(for example, treatment is effective)

record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice manager informed us they were unaware of any audits carried out to assess the completeness of these records.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. Non-clinical staff had not received training in the Mental Capacity Act 2005.

Patients living with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The practice kept records and showed us that 38 out of 39 patients care plans had been reviewed in the last year. The practice nurse demonstrated that one patient chose not to attend and had received regular correspondence and encouragement by the practice staff. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

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 discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. 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

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 233 patients in this age group took up the offer of the health check. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 54 patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking during the 12 weeks sessions was five. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme between April 2013 and March 2014 was 75.91%, which was below the national average of 81.89%. There was a policy to offer three reminders for patients who did not attend for their cervical screening test. The practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. We found that 58.0 % of 60-69 year olds were screened for bowel cancer in the last 30 months which was higher than the CCG average and similar

Good

Are services effective?

(for example, treatment is effective)

to the national average. The practice manager was able to provide figures which included patients up to 74 years as screening was available to them from 2014 which was 56.8%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

• Flu vaccination rates for the over 65s were 65.29%, and at risk groups 35.74%. These were both below the national averages of 73.24% and 52.29% respectively.

• Childhood immunisation rates for the vaccinations given to under twos ranged from 88.5% to 96.2% and five year olds from 90.7% to 97.7%. These were comparable to the CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015 and the Friends and Family Test. The practice was in the process of setting up a patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example:

• 82% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 83.7% and national average of 87.2%.

• 86% said the GP gave them enough time compared to the CCG average of 82.3% and national average of 85.3%.

• 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 90.1% and national average of 92.2%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five comments were less positive which included difficulties experienced gaining telephone access to appointments and that internet appointments were limited. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical staff. Four provided both positive and negative comments. For example one patient found access to appointments problematic, two felt that staff did not always listen to their opinions and one patient commented they did not get the opportunity to speak with privacy in the waiting room. The GPs informed us that they had listened to patient opinions in respect of access and ensured an additional staff member now supported the reception team for thirty minutes each morning.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Washable 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was not located away from the reception desk but was shielded by glass partitions to help keep patient information private. There was no system in place to allow only one patient at a time to approach the reception desk. Eighty point nine percent of patients said they found the receptionists at the practice helpful compared to the CCG average of 86.2% and national average of 86.9%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. This policy assisted staff and would be used to diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

• 77% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 78.4% and national average of 82.0%.

• 71% said the last GP they saw was good at involving them in decisions about their care which was in line with the CCG average.

There was evidence of care plans for vulnerable patients and patient involvement in agreeing these and end of life planning.

Good

Are services caring?

The majority of patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. The majority but not all patients 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 positive overall and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. However we did not see notices in the reception areas to inform patents that this service was available.

Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

• 80% said the last GP they spoke to was good at treating them with care and concern which was in line with the CCG average but lower than the national average.

• 89% said the last nurse they spoke to was good at treating them with care and concern which was higher than the CCG average.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that if families had suffered bereavement, they would contact their usual GP who would ensure they received appropriate support from the practice. This was either a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice assessed patients with long-term conditions and complex needs for anxiety and depression and for those patients who required support longer appointments were arranged.

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 systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example the practice told us they had received CCG Practice Support Visit, and action plans were derived from the visits, they acted as a form of external peer review and they discussed service improvements to better meet the needs of its population. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the CCG. For example the practice had areas for improvement such as frequent attenders at accident and emergency. One GP gave an example that following the implementation of a supportive action plan for one patient, their attendance at accident and emergency had ceased. The practice had implemented a lunchtime children's clinic in order that parents could more readily attend for developmental checks and immunisations.

The practice had implemented suggestions for improvements and made some changes to the way it delivered services in response to feedback from the national patient survey. An example included an additional staff member allocated to work in reception for thirty minutes in the mornings to improve the management of telephone access. However, the practice remained limited to the number of phone lines they had available. Feedback we received from a small number of comment cards and patients spoken with suggested that access to appointments via the telephone remained an issue for some patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had not been designed to meet the needs of people with disabilities but there had been some adaptations made to the premises. The practice facilities were all on one level and there were accessible toilets and baby changing facilities. There was a ramped access to the main entrance of the practice. However, the practice did not have automated doors to assist wheelchair users which made manoeuvring for wheelchair users difficult. This would make movement around the practice easier and help to maintain patients' independence. The practice was accessible to patients with mobility difficulties in that patient facilities were all on one level. The consulting rooms were accessible for patients with mobility difficulties but it was not easy for a wheelchair user without assistance to manoeuvre. There were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams.

Staff told us that they did not have any patients who were of "no fixed abode" but would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records. The practice staff had not completed equality and diversity training.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The practice opening times were 8.30am to 6.30pm Monday to Friday with a late Clinic on Mondays from 6.30 pm, should the Monday be a bank holiday the late clinic date switched to the Tuesday. A locum GP provided Thursday afternoon sessions at the practice, in addition to the out–of-hours provider, Primecare, via the 111 service who took all incoming calls from Thursday afternoons until Friday morning. Any emergency calls to the practice were taken by the GP allocated and the practice used their electronic task system should a patient choose to request a conversation with a GP. The practice data regarding the number of calls taken by the GPs was not collected. Appointments to see the practice nurse were arranged between 8.30am to 12pm and 2pm to 6pm with the

Good

Are services responsive to people's needs?

(for example, to feedback?)

exception of Thursday afternoons. The healthcare assistant provided weekday morning clinics to perform health checks, electrocardiogram (ECG) monitoring (this is equipment used to record the electrical activity of the heart to detect abnormal rhythms and the cause of chest pain); some wound dressings and conduct smoking cessation sessions.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made on request to registered patients in local care homes, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responses to questions about access to appointments. For example:

• 74% were satisfied with the practice's opening hours which were lower than the CCG average of 77% and the national average.

• 59% described their experience of making an appointment as good which was lower than the CCG average of 73% and national average of 73.8%.

• 56% said they usually waited 15 minutes or less after their appointment time which was lower than the CCG and national average.

• 61% said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 71.8%.

The majority of patients we spoke with were satisfied with the appointments system and said it was easy to use. All confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

Routine appointments were available for booking two weeks in advance. However, comments from patients were mixed, some patients spoken with found they could not always pre book appointments due to limited availability and subsequently found difficulty in obtaining same day routine appointments.

Appointments were available outside of school hours for children and young people. The practice had implemented a lunchtime children's clinic in order that parents could more readily attend for developmental checks and immunisations. For patients of working age including student populations a late clinic was available on Mondays. There was an online booking system available and easy to use, telephone consultations where appropriate such as support to enable people to return to work. We saw evidence of how the practice supported patients whose circumstances may make them vulnerable such as longer appointments for those that need them, including for example, avoiding booking appointments at busy times for people who may find this stressful.

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 in the practice brochure, and a suggestion and comment box at the reception area, however there was no complaint leaflet or poster available in the waiting room. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Two of the patients we spoke with told us they had made complaints both had received feedback regarding their complaints.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and demonstrated openness and transparency in dealing with these complaints. We found that verbal comments from patients were not routinely recorded where it was felt they had been dealt with appropriately. For example a patient wishing to book a routine appointment but due to limited availability had been unable to do so, which had caused them to call the practice on more than one occasion. However recording

Good

Are services responsive to people's needs?

(for example, to feedback?)

these comments could assist the practice in identifying trends and action planning accordingly. The practice manager informed us that they hoped to address this further with the support of an active Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example in response to a travel vaccination complaint the practice had ensured that literature was available regarding booking appointments for travel vaccinations in the waiting room and on the practice 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

We saw that the practice had a number of aims and objectives contained within their statement of purpose which included; the provision of timely and appropriate care in a an organisation with a caring ethos, to practice evidenced based medicine, to work co-operatively with the Clinical Commissioning Group (CCG), to provide patient centred care and partake in the friends and family test and to reflect on feedback. These also included their aims to be a good employer to staff, to continue to be a training practice for GP registrars and GP trainees. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Staff we spoke with were unaware of any documented practice vision, strategy or values. Staff told us they considered the practice value would be to provide a friendly caring service and provide the best care possible. The practice did not have a written strategy or business plan in place. A business plan would allow the practice to focus on future planning in taking the practice forward. The GP practice told us they would consider and review this.

We spoke with a number of patients, staff and other health professionals who all spoke very positively about how the practice worked to fulfil its aims and objectives.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at nine of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner GP was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported and knew who to go to in the practice with any concerns.

The GP partners and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at the weekly practice partner meetings and action plans were produced to maintain or improve outcomes. Information from these meetings was shared with staff in the form of memorandums as the practice did not hold whole practice team meetings.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example the infection control audit. We did not see a written record of these checks however the practice manager and GPs informed us this took place informally every day and assured us they would consider recording these informal checks. We saw evidence to demonstrate that the practice did review the building premises and environment in the practice partner meeting minutes.

The practice did not hold specific governance meetings however the weekly practice partner meetings attended by the practice manager did address issues related to governance. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, induction policy, and management of sickness) which were in place to support staff. The practice manager informed us that the staff handbook was in the process of review and needed to be

Are services well-led?

Good

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

updated. We were told that the staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that all staff were approachable and they each took the time to listen to each other. Staff told us they could add to the practice partner meeting agenda and were from time to time asked their opinion. However, they did not always feel involved in discussions about how to run the practice or how to develop the practice.

There were no whole staff meetings. Staff we spoke with said they had informal group and one to one discussions with the GPs, practice manager and practice nurse. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues with the partners and the practice manager and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. When discussed at feedback the partners assured us that regular whole practice meetings would take place.

We saw that the partners regularly attended CCG locality/ peer support meetings. We found there was a lack of evidence of any wider sharing of information such as significant event analysis (SEA) with the CCG.

External peer review was provided by the local CCG through the Practice Support Visit, which was carried out in March 2015. The reports from the visit identified any areas which required improvement and the practice developed an action plan to address them.

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

The practice encouraged and valued feedback from patients. It had begun to set up a patient participation group (PPG) and reviewed the national patient surveys, the Friends and Family Test results and any complaints received. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. For example they had recently provided an additional reception staff member for thirty minutes each morning to assist with the number of calls received. The impact this had to patients experience had yet to be evaluated.

The practice had gathered feedback from staff through appraisals and informal discussions. Some staff spoken with had found that issues raised at appraisal had not always been addressed, or a written explanation or rationale given as to why they could not be addressed. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that requests for practice specific training was in general always agreed and felt engaged in improving 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. Staff told us that the practice was very supportive of training and external trainers attended on occasion.

The practice was an accredited GP training practice. The practice had developed a positive reputation as a supportive location for GP Registrars to further develop their skills. We saw evidence of regular mentoring, training and feedback for GP Registrars and positive outcomes.

Discussions with staff and records showed that staff received role specific training to develop their roles and improve outcomes for patients. The practice had a motivated staff team with extensive experience and skills, to enable them to deliver well-led services.

The practice had completed significant events, incident reviews and audits but these were not shared with all staff, the GP trainees, or at the CCG locality/peer group meetings as a learning and development opportunity. The practice was able to demonstrate improved outcomes for patients following significant events and other incidents.