Dr V H Barry, Dr N C Boelling, Dr J R Eustace and Dr M Gallagher

Quality Report

Emersons Green Medical Centre,
St Lukes Close, Emerson Green,Bristol BS16 7AL
Tel: 0117 957 6000
Website: www.emersonsgreenmedicalcentre.nhs.uk

Date of inspection visit: 16 April 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

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 9

Detailed findings from this inspection

Our inspection team 10

Background to Dr V H Barry, Dr N C Boelling, Dr J R Eustace and Dr M Gallagher 10

Why we carried out this inspection 10

How we carried out this inspection 10

Detailed findings 12

Overall summary

We carried out an announced comprehensive inspection at Emerson Green Medical Centre on 16 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was good for providing services for older patients, patients 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 and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients were kept safe because staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. There were systems in place to keep patients safe from the risk of infection.
- Information about how to complain was available and easy to understand
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Not all patients found it easy to book a routine appointment however most patients reported they got an appointment when needed.

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

The provider should:

- Introduce a system for monitoring records of staff training.

Letter from the Chief Inspector of General Practice

Summary of findings

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. Risks to patients were assessed and well managed.

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 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 for all staff, although some staff told us their appraisal was overdue. 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 higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice's electronic patient record system alerted GPs and other staff if a patient was also a carer.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had good facilities and 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 and appropriately to issues raised. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG).

Summary of findings

Are services well-led?

Good 

The practice is rated as good for well-led. There was a clear leadership structure and staff felt supported by senior management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 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, for example, children and young people who were experiencing high risk domestic abuse. Immunisation rates were high than the local average for all 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 health visitors and school nurses.

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

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 had carried out annual health checks

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and this included attendance at case conferences where a child was at risk of serious harm. 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.

The practice had engaged with the South Gloucestershire Partnership Against Domestic Abuse (SGPADA) IRIS project (Identification and Referral to Improve Safety for women) to support identification and referral of victims. As domestic abuse impacts health the practice staff had received training in relation to domestic abuse identification and referral pathways for victims and their families. Police incident reports are cascaded daily to GPs and there are care pathways that ensure identification and onward referral and care of victims of domestic abuse.

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). 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 and worked with patients and families to ensure any DNACPR (do not attempt cardiopulmonary resuscitation) decisions were appropriate and kept under review.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients visiting the practice and two members of the patient participation group (PPG) during our inspection. We reviewed 7 patient comment cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw the comments were generally positive. Patients told us the practice was clean and hygienic; staff were caring and empathetic whilst treating patients with dignity and respect; staff were helpful and provided a good service. Some patients told us that they experienced problems getting a routine appointment and would have to wait two weeks to see a GP of their choice.

The PPG members we spoke with told us the practice manager actively engaged and supported the group and the staff were aware of the different needs of the practice population. The GP partners attend alternate PPG meetings and were receptive and interested in improving patient experience. We saw the results of the March 2015 PPG survey. We could see evidence during our inspection that the practice was in the process of addressing some of the priority areas such as starting a patient newsletter to increase communication methods and addressing privacy in the reception area. The PPG told us that the wait for a routine appointment with a GP of choice, for some patients, can be up to four weeks. They also told us the quality of medical service was outstanding.

We looked at the NHS Choices website to look at comments made by patients about the practice. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received).

We looked at data provided in the most recent NHS GP patient survey (January 2015) and the Care Quality Commission's information management report about the practice. 77% of patients describe their overall experience of this practice as good in the 2014 patient survey. This is below South Gloucestershire CCG average for overall experience (84%) and National average (86%).

We also looked at the data provided by NHS England for the Friends and Family Test (FFT) in February 2015. The FFT is a feedback tool which offers patients of NHS-funded services the opportunity to provide feedback about the care and treatment they have received. 20 out of 22 patients would recommend the service they have received to their friends and family.

Dr V H Barry, Dr N C Boelling, Dr J R Eustace and Dr M Gallagher

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, CQC inspectors and a practice nurse and practice management specialist.

Background to Dr V H Barry, Dr N C Boelling, Dr J R Eustace and Dr M Gallagher

Dr V H Barry, Dr N C Boelling, Dr J R Eustace and Dr M Gallagher (also known as Emerson Green Medical Centre) provides primary medical services to approximately 10,500 patients living in Emerson Green, a residential area in South Gloucestershire on the northern outskirts of Bristol. The practice is situated next to a nursery school and local shopping centre. Emerson Green NHS Treatment Centre is located close by.

The surgery was purpose built in the 1990's to serve the new residential area and is leased to the practice by NHS Property Services Ltd. The building is set over two floors with all patient access areas on the ground floor. It has an access ramp to the entrance of the building and a large car park with disabled parking and a bicycle rack. Bus stops are located a short walk from the practice. There is a separate reception area with an automated arrival system and spacious waiting room. There are nine clinical rooms.

Public Health England's national general practice profile shows the practice has a significantly higher population of female patients aged between 30 and 49 years old and male patients aged between 35 and 44 years old. There are no residential or nursing care homes within the area. The practice describes the population as predominately professionals and young families and this is reflected in the national general practice profile which lists 9.2% of the practice population as over 65 years of age (averages across England is 16.7%). The practice population has low levels of deprivation (8.13) compared with the local CCG average of 11.2 and England average of 22.1.

The practice team includes three GP partners; three salaried GP's and a GP Registrar (in addition one GP is currently on maternity leave); four registered nurses including a nurse manager and an independent nurse prescriber. Two nurses are currently undertaking advanced nurse training. The nursing team are supported by two experienced health care assistants. A practice manager is supported by an office manager who leads a reception team of seven; administration team of six and a business support coordinator. There is a mix of female and male GP's plus three female and one male nurse. These staff provide care and treatment for approximately 10,500 patients.

Detailed findings

We also had the opportunity to speak to a Locum GP during our inspection. The practice currently uses a regular Locum to cover two sessions a week.

The practice also worked with community staff including Health Visitors who were based at the practice; a Midwife; a District Nursing team; an Emergency Care Practitioner (commissioned by South Gloucestershire CCG to provide urgent home assessments); a Physiotherapist; Dietician and Podiatrist.

The practice is commissioned to provide primary medical services by NHS England under an Alternative Provider Medical Services (APMS) contract. The contract has been in place for seven years and is currently being reviewed in advance of October 2015 when a new contract will be awarded.

The practice has opted out of providing out-of-hours services to their own patients. Patients can access NHS 111 out of hours and Brisdoc provide an out-of-hours GP service.

A new area of housing estate and business park is planned for the area which will result in 3,000 new residents who will register at this and another local GP practice. This had been incorporated within the business continuity plan for the practice.

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

We carried out an announced visit to the practice on 16 April 2015 when we spoke with staff and patients, looked at documentation and observed how people were being cared for.

In advance of the inspection we reviewed the information we held about the provider and asked other organisations to share what they knew. We spoke with South Gloucestershire Clinical Commissioning Group, NHS England area team and South Gloucestershire Healthwatch. We sent comments cards to the practice in advance of our visit for patients to complete. We also spoke to Health Visitors and District Nurses who provide care for patients registered at the practice.

Dr Barry was unavailable during our inspection. As the Registered Manager for the practice and the Safeguarding Children Lead we spoke with them in-depth via the telephone after 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 whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

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 practice manager told us and provided evidence of a thorough, detailed complaints process.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example one receptionist told us about a concern she had for an unborn baby and how she reported the concern to a GP. The GP then spoke to us about the actions they took which included multi agency discussions.

We spoke with the GPs and clinical staff and reviewed the incident reporting policy, safety records, incident reports and minutes of meetings where incidents were discussed for the past 15 months. 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 for the six significant events that had occurred during the last 15 months and we were able to review documentation and speak to staff about them. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events. We were given an example of an incident where a specimen was wrongly labelled for a patient with severe kidney disease. The GP's decided that the management of the incident including any actions needed would be escalated and dealt with prior to any planned review meetings to immediately prevent further incidents. There was evidence that the practice ensured that any incidents that would impact patient care were escalated and managed immediately. We also saw that the practice had learned from these incidents and that the findings were shared with all staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice manager showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We reviewed medical records and saw evidence of an accountable action taken as a result of a delayed diagnosis of appendicitis. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to clinical staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. Relevant safety alerts are discussed at the weekly GP meeting and cascaded to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Alerts relating to medicines were discussed with the practice pharmacist.

We were given examples of how a flu management alerts around the use of medication resulted in a protocol for clinicians undertaking the triage role so that they could effectively prescribe medication they seldom used.

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. For example all of the practice staff had attended training in relation to domestic violence as part of participation in the IRIS scheme (Identification and Referral to Improve Safety for women). 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 hour. Contact details were easily accessible.

The practice had appointed one dedicated GPs as lead in safeguarding vulnerable adults and one dedicated GP as lead in safeguarding children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. South Gloucestershire

Good

Are services safe?

Clinical Commissioning Group (CCG) told us the practice regularly engaged in meetings for safeguarding leads, were 100% up to date with level 3 safeguarding training and that they were fully compliant with a recent safeguarding children audit. The Lead GP for safeguarding children told us about quarterly learning meetings held by the CCG which focused on serious case reviews. Trainee GP's at the practice were encouraged to attend. The Lead GP told us how they would disseminate learning to update practice staff.

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 and families experiencing domestic abuse. The lead GP attended children protection case conferences where appropriate and reports were sent if staff were unable to attend.

We spoke to the Health Visitors who told us they met with the GP's monthly to discuss any families where there were concerns such as looked after children, children of substance abusing parents or young carers and reported that communication regarding individual patients was good.

A partner organisation gave us an example of an incident where a concern about a women and her child experiencing abuse was emailed rather than telephoned from the practice. We addressed the concern with the GP Lead for safeguarding children who agreed actions to ensure staff correctly understood protocols.

There was a chaperone policy, which was visible on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act 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. Patients told us they were aware of the availability of chaperones if they required it.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. We found that keys to the medicine fridge were kept in a key cupboard overnight with the key remaining in the lock. We also found concerns over the security of codes for medicine cupboards. Whilst no incidents had occurred we raised concerns that cleaners had access to the rooms so the medicines were not only accessible to authorised staff. Nursing staff took immediate action to rectify the concerns and review the medicines policy. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

We saw evidence that alerts around a medicine used to treat nausea, had resulted in a search of the patient record system to determine who was prescribed this medication. Those patients at risk, such as older people, had been reviewed and a decision was made to provide alternative medicine. Patients who continued with the medicine were appropriately reviewed based on the safety alert.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Good

Are services safe?

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice. However on the day of our inspection we found an unattended, unlocked clinical room where blank prescriptions were not kept secure at all times. We spoke to the practice who assured us that practice policy was to lock unattended clinical rooms and in this case had been left open and unattended for the ease of the inspection team. After the inspection the practice sent an email to confirm that locking of clinical rooms had been reinforced to staff in a team meeting.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The cleanliness of the building is maintained by a contracted company which had guidelines for their staff on cleaning of medical premises.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received training about infection control specific to their role and received annual updates which included hand hygiene techniques. We saw evidence that the lead carried out three monthly comprehensive audits. We saw evidence that the lead had raised concerns with the local hospital following an increase in post-operative wound infections which resulted in a reduction of infections.

An infection control policy was 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. We were told There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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 that can grow in contaminated water and can be potentially fatal).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.

The practice had a policy for the minimisation of risk from legionella. We saw records for the practice that confirmed monthly checks were carried out according to the policy to reduce the risk of infection. The practice had a named person responsible for implementing the policy who refreshed their training every three years.

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 a register maintained. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometer.

There were records for servicing to the boiler and weekly fire alarm testing.

Staffing and recruitment

The practice had an employee management policy with a thorough recruitment process. Five staff files we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and criminal records checks through the Disclosure and Barring Service (DBS). We found clinical staff files lacked evidence of on going professional registration checks with the appropriate professional body. Prior to our inspection we checked clinical staff were registered with the relevant professional bodies. We found all staff to be registered however one member of staff had not updated their employment details.

All staff were provided with a comprehensive staff handbook which included a whistleblowing policy and

information on diversity. Locum GP's were provided with a welcome pack and check list. We looked at staff files for the locum GP's and found them to be very thorough and well organised. The practice used regular locums and did not employee them through an agency.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a detailed rota system in place for all the different staffing groups to ensure that enough staff were on duty and this was reviewed six weeks in advance to plan for times of increased work pressure for example after a bank holiday. We saw evidence that the practice was currently undertaking an audit around appointment availability following the patient survey where 42% with a preferred GP usually get to see or speak to that GP and the patient feedback on NHS Choices. Since our visit and as a result of the audit the practice had responded and are in the process of recruiting a new GP to increase routine appointments.

The practice had a good annual leave process which ensured and adequate amount of GP cover. GP's had a buddy system in place.

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 annual and monthly 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 and there was an identified health and safety representative.

We saw that any risks were discussed within meetings. For example, the nurse manager had shared the recent findings from an infection control audit with the team.

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. The practice had an urgent clinic to deal with emergencies from 8am to 6.30pm weekdays. A nurse and GP were available to deal with emergencies only during this time. Reception staff had received training in serious underlying symptoms that may indicate a need to prioritise care to an emergency service such as an ambulance.

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 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. We saw that the electrode pads for the defibrillator were out of date (these are a necessity to ensure staff can give a life-saving shock to a patient). The nurse manager immediately rectified this. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. We found that the combination door lock for the medicines had the same code as access doors. These medicines 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 policy was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. The practice had tested access to their systems from a contingency site in case an emergency led to the practice being closed. The document also contained relevant contact details for staff to refer to and who was responsible for what needed to be carried out.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire safety awareness and fire extinguisher training. An evacuation procedure was in place.

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 minutes of meetings where new guidelines were disseminated, 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.

The GPs told us they had lead responsibility for specialist clinical areas and internal referral between clinicians took place for a variety of conditions such as diabetes and respiratory disease. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice nurses held specialist training qualifications in order to hold nurse led clinics. The nurses also assessed and treated patients for minor illness. Clinical protocols were in place. Clinical supervision and fortnightly nurse meetings included patient reviews to ensure effective, good quality patient care was provided. Our review of the clinical meeting minutes confirmed that this happened.

The practice manager showed us the quarterly report that is sent to NHS England as part of the monitoring and contract management for the APMS contract. The data compared performance with local CCG and national averages and allowed the practice to routinely measure their performance. We found the data from the local CCG of the practice's performance for antibiotic prescribing, which was better than the CCG average. This demonstrated that the practice was proactive in the monitoring and prescribing of antibiotics. The practice used computerised tools to identify patients with complex needs.

Patients with chronic diseases or receiving end of life care had multidisciplinary care plans documented in their case notes. We saw that multidisciplinary working between the practice, the hospice and palliative care nurses took place to support these patients and regular meetings were held to review care. We saw that the practice had an end of life care register and alerts within the clinical records system made staff aware of additional needs. The local CCG data showed that the management of end of life care was better than the local average.

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 patients with suspected cancers. We looked at patient records and saw that they were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were 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

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 to carry out clinical audits.

We saw that most of these audits were of good quality and focused on medicines. The practice undertook three monthly prescribing audits with the local CCG pharmacist. The practice demonstrated that they had undertaken medicines audits following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to prevent nausea. The aim of the audit was to ensure that all patients prescribed this medicine were not put at risk of harm. The audit demonstrated that 39 patients were prescribed this medication. The information was shared with GPs and patients were called for a medication review. A second audit was completed one year later which demonstrated that 22 patients continued to receive the medication. We saw that the rationale why patients remained on this medication was acceptable. For

Good

Are services effective?

(for example, treatment is effective)

example a contraindication or adverse reaction with another medicine. Other examples included an audit on the provision and performance around urgent care they provided and compared this with local and national averages; a yearly audit of telephone assessments which included clinical reviews of medical records; monthly audit by nurses of cervical smear results and an audit of post-operative wound infections which resulted in liaising with the local hospital and an improved rate of hospital discharges with a wound infection. The practice had fewer examples of audits around clinical care.

During our visit we received feedback from other organisations. One had raised concerns around GP engagement with home visits for end of life care. We raised these concerns with the practice and they were aware of the issues and had begun addressing the concerns and had undertaken an audit in respect of home visits and the criteria for these, in line with patient need.

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).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, in 2013/2014 the practice had achieved 100% of QOF points in the management of asthma, atrial fibrillation, diabetes, depression, dementia chronic kidney disease and epilepsy. In addition it scored 100% for palliative care and for meeting the needs of patients with learning disabilities.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake an audit for appraisal processes.

There was a protocol for repeat prescribing which followed national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included 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 GP's with interest in sexual health and reproduction, musculoskeletal pain and safeguarding children from abuse. 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 which were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example two nurses were currently undertaking a university course on minor injuries and illnesses in children. As the practice was a training practice, GP's 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 trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, tissue viability wound care, cervical cytology and yellow fever vaccination. Those with extended roles seeing patients with long-term conditions

Good

Are services effective?

(for example, treatment is effective)

such as asthma, respiratory disease and diabetes as well as minor illness were also able to demonstrate that they had appropriate training to fulfil these roles. Health care assistants had undergone additional training to allow them to administer flu vaccination.

We saw evidence that poor performance was challenged and appropriate measures put in place to improve practice such as coaching.

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. We saw evidence that vulnerable patients were followed up after hospital discharge.

The practice held weekly multidisciplinary team meetings to discuss the needs of complex or vulnerable patients for example those with end of life care. These meetings were attended by the community matron, district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Monthly meetings to discuss needs of children on the at risk register were held with the Health Visitor. Staff felt this system worked well and remarked on the importance in understanding what is happening in a patient's life as this enabled collaborative working and supported patients. We saw evidence of opportunities for reviews and case discussions outside of planned meetings.

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 that the computer system had template referral forms. We were told that a dedicated administrator checked and processed the referrals. All referrals made by a locum GP are checked weekly by the GP partners to ensure appropriate referrals are made and they meet the practice's quality checks. We were told that the practice looked at trends in referrals and investigated them. For example there had been a recent rise if referrals for lung cancer.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that 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 in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a protocol to help staff, for example with making do not attempt cardiopulmonary resuscitation (DNACPR) orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. We saw evidence that concerns around capacity or DNACPR was shared with out of hours GP's, community nurses and ambulance services.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting capacity and consent for specific interventions. We saw evidence in the timetable for weekly in-house education sessions that training had been booked for all staff in assessing capacity.

Good

Are services effective?

(for example, treatment is effective)

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 not practice policy to offer a new patient health check to all new patients registering with the practice. New patients completed a registration form that included lifestyle information which helped staff identify patients who may require health promotion and support. For example stop smoking support or screening if there was a known family medical history. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous 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 recorded those that had received a check up in the last 12 months.

We saw evidence that all relevant practice staff had undertaken eLearning on stop smoking intervention. The practice had also identified the smoking status of patients over the age of 16 and offered a stop smoking service with the practice nurses. The percentage of patients with physical and/or mental health conditions whose notes record smoking status and alcohol consumption was above the national average. Exercise on prescription was available to help patients who were overweight.

The practice's performance for cervical smear uptake, by December 2014, was 83%, which was better than others in the CCG area. There was a policy to offer reminders for patients who did not attend for cervical smears which included an on-screen alert during GP appointments. The practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel vaccines including yellow fever and flu vaccinations in line with current national guidance. Last year's performance for flu vaccinations was above average for the local CCG area.

The practice proactively identified carers and had a practice booklet available in reception and on their website for carers, which provided support and signposted patients to support organisations. A register of patients who were carers for family members was kept.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. The practice website contained information for patients on healthy living, self-help for common illnesses and links to other websites containing health promotion and prevention information.

The practice has a regular drop in 'No worries' clinic, providing confidential sexual health and relationship advice for 13-20 years olds. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice had installed a self-check area near the waiting room where patients could check their height, weight and blood pressure.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction and compared this with averages for the local Clinical Commissioning Group (CCG) and England. This included information from the national patient survey (January 2015) which received responses from 125 of the 379 patients (a return rate of 79%). 77% say the GP was good at treating them with care and concern (which is below local CCG and national average of 82%); 80% say the GP was good at involving them in decisions about their care (which was above CCG and national data) and 84% say the nurse was good at treating them with care and concern (which was above CCG and national data). The NHS Friends and Family Test (FFT) in February 2015 showed that 91% of 22 respondents would recommend the practice. This is above the average for the area (84%) and national average for England (88%).

We spoke to the practice patient participation group (PPG) and reviewed a survey (February 2015) of patients undertaken by them. 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 83% of practice respondents say the GP was good at listening to them.

We reviewed comments on NHS Choices and saw that 14 of 16 patients had awarded three stars for treating people with dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 7 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. Two comments were less positive about the availability of routine appointments however they were happy overall with the service they received. We also spoke with 6 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that one occasion when the waiting room was quiet we could overhear a patient proving personal details about their medical needs. We saw a confidentiality statement was provided offering patients the opportunity to speak to staff in a confidential area. Patients we spoke to were aware that they could ask to speak to staff confidentially and in private.

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 he would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that patients were often frustrated when appointments were unavailable and this could lead to anger. Staff told us they could rely on senior staff to help diffuse potentially difficult situations. We were shown minutes of a recent incident review meeting following an episode of aggressive behaviour that showed appropriate actions had been taken. There was also evidence of learning taking place. Receptionists had received no formal training in conflict management.

Good

Are services caring?

We saw that the practice displayed notices offering chaperones. Reception staff were comfortable offering patients chaperones if they were known to be vulnerable or were required to have an intimate examination, for example a cervical smear.

A receptionist told us about a patient who rang the surgery at the end of the day after they had just been diagnosed with cancer. The receptionist told us how they had booked them in for an urgent telephone call so the patient did not need to wait until the next day. This showed that staff were sensitive and sympathetic to patient's needs.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 80% of practice respondents said the GP involved them in care decisions and 79% felt the GP was good at explaining treatment and results. Both these results were average for the South Gloucestershire CCG area.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

We saw care plans for patients with long term conditions or at the end of life. The care plans were well structured and detailed and patient involvement in agreeing these was evident.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were positive about the emotional support provided by the practice and rated it well in this area. For example, one patient told us that staff had given the patient the time they needed when they were vulnerable and feeling sensitive. These highlighted that staff responded compassionately when they needed help and provided support when required.

Information in areas accessible to patients and the practice website provided information on a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer, vulnerable or receiving end of life care. We saw the practice booklet available to carers which included contact details of support organisations available to them.

The PPG survey in February 2015 asked patients what additional services they would like to see at the practice. The most common request was for a counselling service to be available at the practice. We saw evidence that the practice is looking into the request. Staff told us about the LIFT psychology service and gave examples of patients that they had referred to the service for 'stepped care'. This included patients suffering from loss or bereavement.

Staff told us that if families had experienced bereavement, their usual GP contacted them and offered support.

A nurse gave examples of telephoning patients the next day to ensure they were supported and understood how to manage their illness. The nurse told us that they always asked patients if there was something that the practice could do better.

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. A review of the practice contract with NHS England is in progress which includes a questionnaire for patients to complete.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and reviewed other sources of patient feedback including complaints. The representatives from the PPG said the practice listened to them about the comments patients made about the service. We saw evidence that the practice used the information to improve services for example the practice undertook a review of urgent care appointments and are in the process of producing a quarterly newsletter.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example a regular clinic was available at the surgery for patients with substance misuse problems and the practice had an alert on the computer system for vulnerable patients and adult carers.

The practice had access to online and telephone translation services. A hearing loop system was available.

The premises and services had been adapted to meet the needs of patient with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The clinical area for patients is on the ground floor. The first floor has no lift access.

The staff handbook provided comprehensive information on equality and diversity in the workplace for employees. We saw no evidence that equality and diversity training was provided to staff.

Access to the service

The practice is open from 8am to 8pm Monday to Friday and 8am to 5pm on Saturdays. Appointments with GP's and practice nurses were available during these times on weekdays. At weekends the practice opens on Saturdays providing appointments with the nurse in the morning and GP in the afternoon. On weekdays the practice provides an urgent care triage service from 8am to 6.30pm. They also provide on the day appointments with GP's. The GP's work a shift pattern so are not available to patients every weekday.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to cancel appointments through the website. Currently appointments can be made in person or by telephone. 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 patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Two CQC comment cards and feedback on NHS Choices indicated that there could be a two to three week wait for routine appointments. This was not collaborated by recent patient surveys. We discussed this with the practice and were shown a recent review of urgent care. We were told that there was a review of routine appointments in progress. The practice has since notified us of an increase of appointment availability.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice's demographic showed a higher than national average group of 30-49 year olds which made extended opening hours on evenings and Saturdays particularly useful to patients with work and family commitments.

In response to information we received prior to our visit we raised the issue of home visits for patients who are housebound or are receiving end of life care. The practice provided us with an audit that they completed after our inspection. The results showed that all requests were responded to in a timely manner and over half received a GP visit. The other requests received an appropriate response including emergency care, a visit from another health professional and telephone contact from the GP.

Listening and learning from concerns and complaints

The practice had a good process and 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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system within the practice and on their website. The practice also offered patients the opportunity to provide comments and feedback via the website and a comments box within the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at patient reviews on NHS Choices and 14 complaints (of which 3 related to administration and 11 to clinical practice) received since April 2014. We found that all complaints had been investigated and following this patients had received a written reply within 3-4 weeks. We found the written responses from the practice to be open and transparent with the appropriate level of apology. Reviews on NHS choices received a timely response and the practice manager provided direct details for patients to contact him.

We identified no themes from the practice complaints log. We saw that three out of seven reviews on NHS Choices were complaints about the practices appointment system. The practice had an average rating of two stars with regards to appointments. We discussed this theme with the practice so we could establish if the availability of routine appointments met demands. The practice does provide a on the day urgent care appointment system. When these appointments are booked patients have the opportunity to speak to a clinician by telephone. We saw that the practice had recently undertaken an urgent care audit and was reviewing the availability of appointments and increasing GP availability.

The practice reviewed complaints weekly at the partners meeting to detect themes or trends. We saw that patient feedback is a standing item at the practice meeting. We saw from meeting minutes that lessons learned from individual complaints had been acted on For example we saw that a protocol regarding specimens had been changed following two complaints about urine samples.

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 an ethos to deliver patient centred care, to empower patients and ensure staff had the right clinical skills to meet the needs of the practice population. The ethos was not written down within a business plan or practice strategy or accessible to patients. Staff were aware of the practice ethos and knew what their responsibilities were in relation to these.

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 a range of these policies and procedures and saw they had been reviewed regularly 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 the senior partner was the lead for safeguarding. There were leads for clinical governance, and a GP led the support for the trainees at the practice. We spoke with seventeen members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff had access to a staff handbook that included policies such as whistleblowing and set out expectation son staff behaviour and conduct.

The practice used the Quality and Outcomes Framework (QOF) and key performance indicators as part of their NHS contract to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at meetings and action plans were produced to maintain or improve outcomes.

The practice had carried out a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, there was not a planned programme of audits in place.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us risk assessments which addressed a wide range of potential issues and action plans had been produced and implemented. For example, ensuring the premises maintenance was managed appropriately; fire safety; loss of domestic services; prevention of the legionella virus and control of substances harmful to health (COSHH). We saw that risk was regularly discussed at meetings and updated in a timely way so patients received improved quality of care. We saw that blank prescription forms were not subject to a risk assessment and all security of prescription form procedures were not in place.

The practice held weekly partner meetings and regular practice meetings where governance was discussed. We looked at minutes from meetings and found that performance, quality and risks had been discussed.

Nursing staff including health care assistants received clinical supervision and took part in weekly clinical review meetings as well as a fortnightly nurse meeting.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Salaried, trainee GPs and locums were included in meetings and this was reflected in the conversations and feedback where they felt included and valued in the running of the practice.

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

The GP partners are available at lunchtime daily in the staff room so that they are accessible to staff who can raise any concerns informally.

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

The practice had gathered feedback from patients through patient surveys, comment cards, NHS Choices reviews, and complaints received. We looked at the results of the PPG survey in October 2014 where patients found the different appointment types to be complicated. We saw as a result of this the practice had introduced guidance on the different appointments available and how patients could book them.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups. The PPG had carried out surveys when required and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they could identify additional training.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff were regularly consulted by senior management when service changes are being considered.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included training and development needs. We looked at training and saw that there was not a training needs analysis for the practice however there was a mandatory training matrix. The training record system relied on a manual process and we saw that it was difficult to interpret how many staff had received training, for example safeguarding training.

Weekly learning and development sessions were held for staff. We saw the timetable which included incident reviews, mental capacity, medicines management, clinical conditions and reviews of journal articles. Staff also attended learning events organised by the local CCG and LMC (local medical committee).

The practice was a GP training practice with one partner taking the lead for GP training. The GP also undertook a mentorship programme for newly qualified GP's. We spoke with the GP currently training at the practice who had attended safeguarding lead meetings where learning from serious case reviews was provided.