Derby Open Access Centre

Quality Report

207 St Thomas Road
Derby
Derbyshire
DE23 8RJ
Tel: 01332 275610
Website: www.onemedicare-derby.co.uk

Date of inspection visit: 08 December 2014
Date of publication: 04/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced comprehensive inspection at Derby Open Access Centre on 08 December 2014 when we looked at both the walk-in service and the GP service for registered patients. Overall the practice is rated as good.

Specifically, we found both parts of the service offered by the practice to be good at providing safe, well-led, effective, responsive and caring services. It was also good for providing services for older people, people with long-term conditions, mothers, babies, children and young people. It was also good for providing services for people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health. It was outstanding for providing services for working-age people and those recently retired.

Our key findings across all the areas we inspected 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.
- 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.
- 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 was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP or a nurse and that there was continuity of care, with urgent appointments available the same day or through the walk-in service.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

We saw one area of outstanding practice:

Summary of findings

- The practice had evolved an outreach programme where seasonal, bespoke sessions were held in community venues, such as school halls and business premises around two to three times each month. The most recent programmes prior to our inspection were the provision of flu vaccinations and the provision of health checks at various community venues. In this way the practice had helped to identify people from the area who had previously unidentified health concerns and encouraged them to seek advice from their own GPs. Whilst the opening hours offered by the walk-in service was good for working age people, we judged it to be outstanding for this population group due to the additional service provided by the outreach work.

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

Importantly the provider should:

- Ensure that effective arrangements are made for patients to speak with reception staff in private if they choose to and that the availability of these arrangements is communicated to patients.
- Take steps to initiate a system that proactively identifies patients who are caring for others so that their needs can be assessed.
- Make information available in the waiting area and in a form that patients can take away with them about how to make a complaint.

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 safe and is rated as good.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to internal staff, other practices in the provider's company and to other practices locally to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed and staff could respond in the event of a medical emergency. There were enough staff and properly maintained equipment to help keep patients safe. Medicines, including repeat prescriptions were managed safely. The practice controlled infection by following safe, hygienic procedures. The practice was equipped to deal with the cessation of any part of the service due to a major event or incident.

Are services effective?

Good

The practice is effective and is rated as good.

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. 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. Patients with complex needs or at greater risk of hospital admission had personalised care plans. The practice was effective at promoting good health and preventing ill-health. The care of patients who were discharged from hospital to a nursing home bed for rehabilitation prior to returning home was supported by the practice through personalised care plans.

Are services caring?

Good

The practice is caring and is rated as good.

Data showed that patients rated the practice similar to others for all aspects of their care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

Summary of findings

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.

Are services responsive to people's needs?

Good

The practice is responsive to people's needs and is rated as good.

The practice 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.

The practice served an inner city area of Derby and had provided a proactive outreach service several times each month in order to provide topical treatments, such as the flu vaccination to people who could not get to the practice, or health checks to people to help identify previously unidentified health concerns. Nationally collected data showed that the practice was among the 25% most effective practices for ensuring patients who were under 65 but in higher risk groups had received a flu vaccination. Patients said they found it easy to make an appointment with a GP. Appointments were available the same day for registered patients. The practice's walk-in service was accessible for both registered and non-registered patients who wished to be seen for a minor illness consultation. 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 with staff and other stakeholders was evident.

Are services well-led?

Good

The practice is well-led and is rated as good.

It had a clear vision and strategy. Staff were clear about the vision and 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 although some had not been updated for over two years. The practice held regular clinical management 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) had been active until recently and the practice was attempting to generate interest from patients to take part. Staff had received regular performance reviews and worked in a learning culture.

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 although this group of patients was very low in number in comparison to the rest of England. 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 double access appointments for those with enhanced needs.

The practice also supported older people through its outreach programme by providing some services, such as the flu vaccination, in community venues for people that could not get to the practice.

Older patients who were discharged from hospital to nursing homes whilst undergoing rehabilitation benefitted from the practice's delayed discharge initiative. Such patients were seen within 48 hours by a clinician and were provided with a proactive personalised care plan to help in their recuperation and ultimate return to their home.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff led 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 structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the 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 looked after or subject of a child protection plan. Immunisation rates were as expected 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 midwives, health visitors and school nurses

Working age people (including those recently retired and students)

Outstanding ☆

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 such as adult health checks.

The practice had a 12 hours-a-day, seven days-a-week walk-in service which it was due to expand to cover a larger population area. This was beneficial to patients in this population group as expected form a service of this nature. However, the practice provided health checks to this group of patients, including people who were not registered at the practice, through its outreach programme and helped to identify underlying health concerns. We consider this to be outstanding practice.

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 patients with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams to support 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.

Some of the staff had learned to speak some basic essential phrases in Polish to assist in communicating with patients in this new community. The practice carried information in a number of different Eastern European languages to help patients understand prescribing practices.

Summary of findings

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). Everybody who experienced poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams to support people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health 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.

Summary of findings

What people who use the service say

The 2014 National Patient Survey data showed that a similar proportion of patients compared to the rest of England were concerned about being overheard at the reception area.

Data from the 2014 National Patient Survey showed that 66% of patients stated they would recommend the practice whilst 75% stated that they felt the practice was good or very good. These were among the middle range of ratings as compared with other GPs both nationally and within the Clinical Commissioning Group (CCG) area. The same was true of the percentage of people who reported that the reception staff were helpful, and those who reported that they were treated with care and concern. These satisfaction rates were similar to the national average and the CCG area.

The National Patient Survey 2014 also showed that, 73% of patients felt the GP was good at giving them enough time, good at listening to them and good at explaining test results to them. The survey showed that 64% of patients felt that the GP was good at involving them in decisions about their care with a slightly higher percentage reported for the nurses at the practice. These satisfaction rates were similar to the average for both the local CCG area and for England in general.

Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of involvement in their care. Some patients told us they felt in control. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. Further, two of the eight comment cards we reviewed reported that patients felt listened to.

The 2014 National Patient Survey results showed that patient satisfaction with the practice's opening hours and their experience of making an appointment was similar to other practices in England in the CCG area at just over 80% on average.

Patients we spoke with on the day of our inspection had no complaints about getting an appointment and told us they could always get to see a GP on the day if they needed to or revert to using the walk-in minor illness service.

A recurring observation from patients we spoke with and from the comment cards we reviewed was that they sometimes had to wait too long to be seen once they had made their appointment. This was borne out by the National Patient Survey data which showed that only 41% felt they don't normally have to wait too long to be seen; lower than the average for the rest of England.

Areas for improvement

Action the service SHOULD take to improve

Ensure that effective arrangements are made for patients to speak with reception staff in private if they choose to and that the availability of these arrangements is communicated to patients.

Take steps to initiate a system that proactively identifies patients who are caring for others so that their needs can be assessed.

Make information available in the waiting area and in a form that patients can take away with them about how to make a complaint.

Outstanding practice

The practice had evolved an outreach programme where seasonal, bespoke sessions were held in community venues, such as school halls and business premises around two to three times each month. The most recent programmes prior to our inspection were the provision of flu vaccinations and the provision of health checks at various community venues. These were run by the health care assistants and the nursing team for any person who

Summary of findings

happened to come to the outreach sessions, not just patients registered to the practice. Nationally collected data showed that the practice was among the 25% most effective practices for ensuring patients who were under 65 but in higher risk groups had received a flu vaccination. The practice had helped to identify people from the area who had previously unidentified health concerns and encouraged them to seek advice from their own GPs. Whilst the opening hours offered by the walk-in service was good for working age people, we judged it to be outstanding for this population group due to the additional service provided by the outreach work.

Derby Open Access Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by another CQC inspector, a GP specialist adviser and a practice manager specialist adviser.

Background to Derby Open Access Centre

Derby Open Access Centre is a community general practice that provides a full range of enhanced primary medical services for just over 5,000 registered patients who live in the Pear Tree area of Derby. The centre also provides a minor illness walk-in service for registered and non-registered patients and has over 30,000 walk-in patient contacts per year. The practice is governed by a parent provider, One Medicare, and is one of nine locations operated by this same provider in different parts of England.

The practice is adjacent to a pharmacy and occupies one part of a purpose built medical centre, a building that it shares with a neighbouring practice.

According to Public Health England, the patient population is culturally diverse and rapidly evolving with a significantly higher than average percentage of patients aged under 39 years as compared with the rest of England, particularly the age groups birth to nine years and 20 to 29 years. There is a significantly lower percentage of patients older than 44 years as compared to the rest of England. The practice is in an area considered to be in the lower 20% of deprived areas in England.

Derby Open Access Centre has six GPs. There are three advanced nurse practitioners (ANP) who can prescribe medicines. The GPs and the ANPs run scheduled appointments for registered patients as well as appointment slots for walk-in contacts. There are also two health care assistants who provide a range of services such as health checks and phlebotomy. The community midwife and health visiting team operate clinics from the practice location.

There is an operations manager and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8am and 8pm, seven days-a-week. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

We conduct our inspections of primary medical services, such as Derby Open Access Centre, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

We carried out an announced visit on 8 December 2014. During our visit we spoke with two of the GPs, the operations manager and members of the nursing team and administration staff.

We spoke with five patients using the service on the day of our visit. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed eight CQC comment cards completed by patients using the service prior to the day of our visit where they shared their views and experiences.

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

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

We also look at how well services are provided for specific groups of people and what care is expected for them. Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, 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. This included comments and complaints received from patients and the analysis of significant events, referred to by the practice as a Significant Event Record (SER). SERs and complaints were dealt with as a standing agenda item at the monthly clinical meetings, but we noted that action to address any immediate concerns was taken straightaway when this was required. For example, in the case of a patient persistently behaving aggressively in the waiting area, the police had been called to ensure they presented no further risk to patients or staff.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report any incidents or near misses using a standardised form. We looked at a number of records raised by different staff members. These related to, for example, patients who presented in an aggressive way, the skill mix and clinical staff rota late in the evening, and one instance of an accident in the waiting area involving a mobility scooter.

The practice was consistent with its approach to dealing with safety incidents over time. For example, we saw the SER logs and the complaints and comments logs for the two years preceding our inspection and saw that they were reported comprehensively then discussed and dealt with firmly and candidly.

Learning and improvement from safety incidents

Our review of the records of SERs that had occurred during the last two years showed that the practice took action to address any concerns, and learned from them as a result. We looked at the minutes of clinical meetings and a copy of the practice's staff newsletter that showed that learning was shared. Not only was learning shared with internal staff, but also with other practices in the provider's company and other local practices.

For example, the repeat prescribing process had identified two separate SERs that related to possible misuse of medicines. These related to two separate patients who were receiving monthly supplies of the regular, preventative medicines used in the treatment of their long term conditions. This indicated that they were either stockpiling the medicines or using them excessively. This prompted reviews of both patients' needs to establish there was no worsening of their conditions and it was decided to remove the medicines from their repeat prescription list. The practice produced a case study of these incidents and shared their learning about repeat prescribing and reducing medicines waste with other practices in the area.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were weekly meetings with the health visitor during which any risks to vulnerable children were reviewed. Practice training records made available to us showed that all staff had received relevant training on safeguarding to the level appropriate to their role, including training in the deprivation of liberty safeguards arising from the Mental Capacity Act 2005.

We asked members of the 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 about documenting safeguarding concerns and how to contact the relevant agencies during and out-of-hours. Contact details for the relevant agencies were easily accessible.

The practice had appointed a dedicated GP and an Advanced Nurse Practitioner (ANP) as leads in safeguarding vulnerable adults and children. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. All clinical staff had been trained to the appropriate advanced level and administrative staff had been trained to the level appropriate to their role that enabled them to identify and respond to concerns or risks. The ANP safeguarding lead was trained to a further advanced level. We looked at the practice's clinical team minutes which showed that safeguarding concerns were discussed and information shared appropriately.

There was a system to highlight vulnerable patients on the practice's computer system. Staff we spoke with told us that this included information on specific issues so they were aware of any relevant background when patients attended appointments; for example children subject of a child protection plan had an icon on their medical record

to indicate that a plan was in place. We saw that vulnerable children and families were identified by the practice and followed up where necessary, such as children of parents who misused drugs or alcohol.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. All nursing staff and health care assistants had been trained to carry out this role.

Medicines management

We found that there were clear procedures for the management of medicines that minimised the potential for error. For example, we found evidence that the nursing team was working with patient group directions (PGDs) that were up-to-date, signed and held on the practice intranet. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before they present for treatment, such as vaccinations or family planning medicines.

We saw that the cold chain was maintained for the storage of temperature sensitive medicines, such as the flu vaccine, from the time they were received at the practice to the time they were administered. There was a policy in place and a system for monitoring the fridge temperatures daily so that the practice was assured the vaccines remained viable and safe to use.

There was some medication, for example, Ventolin nebules and Lidocaine for injection that were stored on the shelves in the equipment room which remained unlocked throughout the day of our visit. This room also contained supplies of syringes and needles and there was a risk that this could be accessed by members of the public. Once we pointed this out it was rectified immediately and we were assured that the practice would take steps following our visit to ensure staff were given clear instructions and made aware of the risks.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked, including those intended for emergency use, were within their expiry dates. Expired and unwanted medicines were returned to the pharmacy for disposal.

The practice did not hold any stocks of controlled drugs.

We found that the practice operated a safe repeat prescription process; prescriptions could be ordered through the practice, online through the practice's patient management system or through the adjacent or other nearby pharmacies. Staff who were responsible for managing the repeat prescription process were trained to do so. The practice followed a standard repeat prescription timescale of 'within 48 hours'. Feedback we received from patients about their prescriptions was good. Patients reported that they experienced no delays in obtaining their medicines and that they always received the medicines they needed.

The repeat prescription process was effective in identifying when patients were due to have a medication review. It was also effective at identifying other issues that affected patients' safe use of medicines. We noted that the process had identified the two separate incidents of stockpiled medicines that we have reported on above.

Cleanliness and infection control

We found the practice to be clean and tidy on the day of our inspection. Cleaning schedules were in place and records were kept that helped the practice to monitor the effectiveness of the cleaning process. Clinical waste and used sharp instruments were disposed of in appropriate bins and containers in accordance with Department of Health guidance. Patients we spoke with told us they always found the practice to be clean and had no concerns about the risks of infection.

A member of the nursing staff was designated as the lead for infection control. They 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 that the lead staff member had carried out a quarterly infection control inspection checklist. This included a random spot check on members of staff being able to demonstrate good hand-washing techniques.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to undertake measures in their everyday work to help control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's

Good

Are services safe?

infection control policy and we saw that these were in use during our inspection. There was also a policy for needle stick injury and staff knew how to respond in the event of such an injury occurring.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice had carried 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. We saw that all equipment, such as blood pressure machines, a spirometer and an electrocardiogram machine, was tested, calibrated and maintained regularly. 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.

Staffing and recruitment

We found that there were arrangements for planning the number and skill mix of staff needed to meet patients' needs, including both clinical and non-clinical staff members. The provider's head office carried out an assessment based on the practice patient list size and the numbers and times of walk-in patients. Staffing levels were monitored effectively and action was taken when any issues arose. For example, we noted that the practice had addressed an issue from the summer of 2014 that related to the late cancellation of shifts by locum agencies.

Reception staff were recruited on the understanding that their working hours were between 8am and 8pm and we noted that there had been no difficulties in recruiting; we saw there were a large number of applications for the last vacant post.

Some staff members worked 12-hour shifts but we noted that this was their choice to do so. There was also a degree of flexibility among the staff to cover each other during times of leave or sickness and the health care assistants could also cover reception duties.

The practice had a recruitment policy that set out the standards it followed when recruiting staff. All employment checks were carried out by the provider's head office although the operations manager kept copies on-site that we were able to refer to. For example, we saw that references were taken up, criminal records checks were carried out through the Disclosure and Barring Service and the status of clinical staff was checked with the General Medical Council and Nursing and Midwifery Council.

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 the practice had a risk reporting tool available to all staff on the intranet and identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at clinical team meetings. There was a process in place to give feedback to the individual who had raised the risk once it had been investigated.

The practice had arrangements in place to manage medical 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 (a device used to attempt to restart a person's heart in an emergency). The members of staff we spoke with all knew the location of this equipment and records confirmed that it was checked regularly. A member of staff was able to describe an incident when a patient had collapsed in the surgery and the actions taken to revive the patient and seek emergency assistance.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, severe shock associated with an allergic reaction to a vaccine, a diabetic emergency and meningitis. 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.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The plan included relevant contact information for local services and commissioners to enable rapid contact to be made with relevant organisations. The plan was kept under review and hard copies were located both on and off-site.

Should evacuation of the practice be necessary the contingency was for patients and staff to use the GP practice next door. If there was a computer failure, the practice's computerised patient management system could be accessed from other practices within the provider's company. The document also contained relevant contact details for staff to refer to.

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 training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. There was a system in place that limited the amount of individuals from each staff group to take planned leave at the same time.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment such as those from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that some of the GPs and the advanced nurse practitioners (ANP) had lead roles in specialist clinical areas such as diabetes, heart disease and asthma, which allowed the practice to focus on specific conditions for its population of registered patients.

We saw that monthly clinical meetings included discussions on expected standards of care. New information or guidance from the Clinical Commissioning Group (CCG) or the NICE quality standards were assimilated during these clinical meetings. As a result, the practice's management plans and protocols for particular conditions or treatments were updated and put into practice. For example, patients with long term conditions were noted on a long term conditions register and we saw that guidance and protocols were followed to ensure their care and treatment was regularly reviewed in line with the guidance. Such patients were recalled by a staff member designated as care co-ordinator which ensured their care and treatment was reviewed in a timely way.

The practice used a risk tool to identify those of its patients that were most at risk of repeated admissions to hospital through attendances at accident and emergency (A&E). Those patients were allocated a named GP and an assessment of their needs gave rise to a personalised care plan. This was also the case for people who were approaching their end-of-life; their specific needs were discussed at multi-disciplinary team (MDT) meetings every three months involving the community nursing team and the palliative care nurses. At the time of our inspection, there were only two patients that this affected among the practice's registered list.

We learned of a particular service provided by the practice, and led by the senior ANP, where patients' delayed discharges from hospital were managed through proactive care planning. Patients who were discharged into short term stays in local nursing homes whilst still recuperating were visited by a clinician to assess their needs within 48 hours of being discharged. This, too, gave rise to a personalised care plan to direct their care and treatment during their rehabilitation period. We learned that this service, which had originally begun as a 'winter pressure' funding initiative, had received favourable feedback from patients through the CCG. As a result the service had continued for the remainder of the previous year and was to continue into its second year.

The practice's patient population was diverse. During our inspection we saw no evidence of any discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

The practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services. The outcomes of these searches were discussed at the monthly clinical meetings. Our own examination of the QOF data showed that the practice was performing well across a range of clinical areas in comparison with the rest of the CCG area and England. For example, the practice was among the 25% most effective practices in England in relation to its rate of prescribing particular types of higher risk, broad spectrum anti-bacterial medicines, non-steroidal anti-inflammatory medicines and a group of medicines known as hypnotics.

The practice also used information from a number of other different sources in order to monitor quality and improve patient outcomes. This included clinical audits of various aspects of their performance and internal reviews against certain criteria, or indicators, set out within the terms of their contract with the NHS. For example, we saw that the practice had conducted an internal review of their referral practices by examining individual cases under three separate referral areas, general surgery, gynaecology and physiotherapy for the whole 12 months for the year preceding our inspection. The purpose of this review was to determine whether the referrals had been made appropriately and see where improvements could be made to referral behaviour, both across the practice and for individual GPs.

The review had identified a number of time-bound actions for implementation across the practice, particularly in relation to physiotherapy referrals. These included

Good

Are services effective?

(for example, treatment is effective)

enhancing and utilising the experience of one of the ANPs in providing guidance to patients about exercise and the implementation of a back pain pathway to reduce the need for referrals. We also saw that the review gave rise to learning points for individual GPs. During our interviews with GPs we learned that these changes had happened but we noted that the planned follow-up review to measure their effectiveness had not yet taken place.

We looked at a clinical audit of higher risk, broad spectrum anti-bacterial medicine prescribing that had involved a review of prescriptions issued to its registered, as opposed to its walk-in patients. This showed that prescribing these types of medicines was generally low and this was borne out by the data available to us as reported above. However, the prescribing of one type of antibiotic by locum doctors for discrete types of infection amounted to 80% of the prescriptions identified as inappropriate. This resulted in the issue of a locum pack to new locum doctors that reinforced the local CCG prescribing policy. We learned that this antibiotic prescribing was to become part of the parent provider's system-wide clinical audit programme for the period following our inspection.

We saw the proactive personal care plans of those patients who were at risk of hospital admissions were also subject of ongoing review by the care co-ordinator to ensure their evolving needs were met.

Effective staffing

Practice staffing included clinical (GPs and nurses) and non-clinical roles (managerial and administrative staff). We looked at records and spoke with staff and found that all staff were appropriately trained and supported to carry out their roles effectively. This was the case for both clinical and non-clinical staff. For example, nursing staff had been trained in immunisations, asthma, diabetes and other long term conditions; the healthcare assistant had received training in carrying out health checks and taking blood samples.

Staff were given protected time to complete any training. We noted that all training the practice considered to be essential, such as basic life support training and safeguarding, was up to date. Training was monitored by means of a spreadsheet database so that the practice management team knew when staff needed refresher training. The practice had recently acquired a computer programme that allowed them to manage all training needs, professional qualifications and clinical registrations although this had yet to be fully implemented at the time of our inspection.

The doctors and the nurses had maintained their continuing professional development requirements in order to ensure their continued registration with their relevant clinical professional bodies.

The practice had arrangements to provide clinical supervision for the nursing staff, an activity that brings clinicians from the same or similar professions and skills together in order to review and improve individual or group performance. This was provided through regular one-to-one sessions with the lead ANP.

All staff received annual appraisals which identified their learning needs and other development opportunities. Their annual activity was objective driven with a personal development plan agreed at each appraisal. Staff appraisal schedules confirmed that this had taken place. Staff we spoke with told us that they felt supported, skilled and valued.

Working with colleagues and other services

We found that the practice engaged regularly with other health care providers in the area such as the district nursing team, the health visitors, the emergency department of the local hospital and the local ambulance service. The evolving needs of each of its registered patients receiving palliative care were discussed at three-monthly MDT meetings. As patients neared the very end-of-life, their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service to ensure that specific wishes about their death could be met, although the number of patients this affected was very small at the time of our inspection.

Blood test results, X-ray results, and letters from the local hospital including discharge summaries were received mainly electronically but sometimes by post. Hard copy material was scanned into the practice's patient management system as soon as it was received. Such information was assigned to clinicians to review straightaway and staff were issued with tasks to take any action arising from this, such as contacting the patient to

Good

Are services effective?

(for example, treatment is effective)

come in for a review or to collect a prescription. There was a system in place to identify when discharge summaries were expected and to follow this up on the infrequent occasions they were not received.

As we have reported above, the practice worked closely with the hospital and local nursing homes to operate a delayed hospital discharge service where the needs of patients discharged to a short term placement at a nursing home were assessed and monitored through a personalised care plan.

Information sharing

The practice used an established electronic patient records management system (known as SystmOne) to provide staff with sufficient information about patients. All staff were trained to use this system. The system carried personal care and health records and was set up to enable alerts to be communicated about particular patients such as information about children known to be at risk.

The practice system was also the gateway to the 'choose and book' system which facilitated the management of referrals on to other services such as the hospital out-patients department. The system also enabled correspondence from other health care providers, such as discharge letters or blood and other test results, to be held electronically to reduce the need of paper held records. This system was readily available and accessible to all staff.

The practice had begun to use the electronic Summary Care Record which enabled faster access to key clinical information about patients for healthcare staff when treating patients in an emergency or out of normal hours. We saw that the practice provided patients with extensive information about the use of their data in this way with a detailed, dedicated section on the practice web-site.

Consent to care and treatment

We found that patients consent to care and treatment was always sought in line with relevant guidance and the practice's clear consent policy. Clinical staff we spoke with understood the processes involved for obtaining consent from patients. This was the case whether consent was implied, such as for a routine consultation, or obtained explicitly in writing for particular treatments, such as minor surgical procedures. Where necessary, consent was recorded as part of the consultation notes on the patient's computerised record.

We found that the practice applied well established criteria used by each clinician to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. We also saw that staff had been recently trained in the application of the Mental Capacity Act 2005. Staff understood the process and reasons for making decisions in patients' best interests where their capacity to consent was impaired, such as decisions about resuscitation in a medical emergency. However, this was a very rare occurrence with the current patient population group.

Patients we spoke with on the day of our inspection told us that they were involved in making decisions about their care and treatment and that they were given sufficient information to make decisions about it.

Health promotion and ill-health prevention

There was a range of up-to-date health promotion literature available in the waiting area with information about physical and mental health and lifestyle choices. For example, we saw that there was information available on diet, smoking cessation, alcohol consumption, contraception, staying warm in winter and about travel.

We saw that all new patients were asked to complete a general health questionnaire when they first registered and were invited into the practice to see a nurse or healthcare assistant for a health check and exploration of their medical history and lifestyle. All patients over 40, including those also over 75, received a NHS health check by healthcare assistants that had been trained to carry this out. The practice also carried out 'well-woman' health checks for all women, whether registered with the practice or not.

The practice ran nurse-led health promotion consultations for long term conditions such as diabetes, chronic lung conditions and heart disease for its registered patients. These were not available for walk-in patients of the centre who were not already registered. We saw that there was also plentiful information available about long term conditions in the waiting area although the practice web-site had very limited information. The practice also opportunistically used consultations with people with long term conditions to follow-up their need for further preventative treatment such as the flu vaccination.

Good

Are services effective?

(for example, treatment is effective)

Nationally collected data showed that the practice was among the 25% most effective practices for ensuring patients who were under 65 but in higher risk groups had received a flu vaccination.

The practice also provided a full range of childhood immunisations and nationally collected data showed that they were reaching generally similar or slightly lower rates in comparison with the rest of the CCG area. The same national data showed that the practice achieved 85% take up rate for cervical smears which was similar to expected rates nationally. The data also showed that the practice was performing as expected for its treatment of patients with preventative anti-coagulation medicines, as well as for those patients living with dementia who had received a face-to-face review of their health needs.

The practice did not proactively take steps to identify patients who were also carers, but any patients who were caring for others were offered additional support. We saw that carers could also be referred to external carer support organisations that could provide additional practical and emotional support.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with five registered patients on the day of our inspection, some of whom were making use of the walk-in minor illness service. We also reviewed eight comment cards that had been collected from patients in advance of our visit, looked at data from the 2014 National Patient Survey and carried out observations throughout our inspection.

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. All of the patients we spoke with reported that their GP and the nurses were courteous, considerate and compassionate. Most patients also told us that all the reception staff were polite and had a pleasant manner with patients. This was borne out during our observations in the reception and administration areas when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk.

With one exception, all of the completed CQC comment cards we received reported wholly positive experiences of patients. Some of the cards referred to GPs and staff by name, singling out individual examples of kindness, care and compassion. One comment card drew our attention to the lack of privacy at the reception desk. The 2014 National Patient Survey data showed that a similar proportion of patients compared to the rest of England were concerned about being overheard at the reception area. However, we noted that the reception area was open-plan and there were no arrangements to allow people to speak with reception staff in private. Neither was there any other information advising patients to respect privacy of others who were at the reception desk. Although we did note that reception staff spoke in low, discreet tones and this minimised the risk of being overheard. The staff we spoke with confirmed that there were no formal arrangements to allow this as patients did not usually want to speak in private.

Further data from the 2014 National Patient Survey showed that 66% of patients stated they would recommend the practice whilst 75% stated that they felt the practice was good or very good. These were among the middle range of ratings as compared with other GPs both nationally and within the Clinical Commissioning Group (CCG) area. Eighty-three percent of patients reported that the reception staff were helpful and this, too, was similar to expected. The experiences of the survey respondents was reflective of the wholly positive experiences of people we spoke with and those largely reported on our comment cards. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (83%) and by their doctor (75%). These were similar to the national and CCG area average.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male doctor. All members of the nursing staff including the health care assistants could carry out the role of chaperone.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey 2014 showed that, on average, 73% of patients felt the GP was good at giving them enough time, good at listening to them and good at explaining test results to them. The survey showed that 64% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were similar to the average for both the local CCG area and for England in general. The corresponding figures for the nursing staff were also similar to the England and CCG average with 84% reporting that the nurses gave them enough time, listened to them and explained test results, whilst 77% felt the nurses involved them in care decisions.

Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of involvement. Some patients told us they felt in control. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. Further, two of the eight comment cards we reviewed reported that patients felt listened to.

Good

Are services caring?

We found that patients who were referred onwards to hospital or other services were involved in the process. We saw that patients could make a choice about where and when to receive follow-up treatment from hospital providers by the use of the 'choose and book' system.

The practice had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved. For example, staff we spoke with told us they were always made aware of the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

The care plans of people receiving end-of-life care and of those patients who were most at risk of unscheduled hospital admissions were discussed at three-monthly multi-disciplinary team meetings. This ensured that the practice could regularly and actively monitor the evolving needs, including emotional needs of these groups of patients.

As we have reported above, the practice did not actively take steps to identify patients who were carers although once known, carers were signposted to other services providing practical and emotional support.

The practice also encouraged patients to consider their own health and medication needs with a prominent notice near the prescriptions information about ordering only what medicines they required and to 'think about seeing the pharmacist'.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice had been running the minor illness walk-in service since 2008. The operations manager explained that this had worked well for an area with comparatively high income deprivation and for a population that was hugely diverse with a variety of demands owing to the very young average age. For instance, the most densely populated age groups were children under nine and adults in the 20 to 29 age group. This gave rise to the need for the treatment of illnesses common in young families and the consequent demands for consultations with little prior notice. We spoke with five patients on the day of our inspection, all of whom were registered with the practice. They told us they felt that the availability of the walk-in service meant they could always be seen on the day if they were ill.

The age ranges of the patient population meant that the practice had had to respond to a need to provide an increased number of family planning services. For example, we saw that the practice ran a specific menorrhagia service which had resulted in an increase in the number of treatments involving long-acting reversible contraceptive methods.

The operations manager and the lead GP attended all local CCG meetings and this had helped them to understand the needs of the local population and plan their services accordingly. For example, we found that the practice health care assistants provided an ear irrigation service for their patient population and also for other practices in the area. The practice presented information to us that showed how this had resulted in fewer referrals to the secondary ear-nose-throat service and had reduced the usual two-week-wait referral time for patients to be treated in this way.

The practice had secured an additional contract to provide another, larger walk-in service from another location due to begin in April 2015. This service was being delivered from the other location by a different provider at the time of our inspection. The practice's existing walk-in service would also move to the new location as part of the new service.

The practice had liaised extensively with the CCG recently to help them to plan how they would deliver the additional walk-in service contract to the much larger population it would serve. These plans would be finalised once the practice had completed a programme of community engagement events it was planning in the months following our inspection as part of the new service's implementation.

The practice had been involved in regular outreach programmes in the surrounding community to ensure that patients who found it difficult to get to the practice could access healthcare. These outreach programmes had begun in 2013 with a three month project in conjunction with the local authority to identify people over 45 who might need a cardiovascular health check. This had involved a series of events at numerous venues where people's height, weight, body-mass index, blood pressure, blood sugar and cholesterol were assessed. The practice presented figures to us that showed how this programme had resulted in around 3,000 people receiving health checks and advice in this three month period.

As a result of the success of this programme, the practice had evolved its outreach work to the point where seasonal, bespoke sessions were held in community venues, such as school halls and business premises around two to three times each month. We saw that, for example, the most recent programmes prior to our inspection were the provision of flu vaccinations and the provision of health checks at various community venues run by the health care assistants and the nursing team. Nationally collected data showed that the practice was among the 25% most effective practices for ensuring patients who were under 65 but in higher risk groups had received a flu vaccination. The health check service was provided to any person who happened to come to the outreach sessions, not just patients registered to the practice. In this way, the practice had helped to identify people from the area who had previously unidentified health concerns and encouraged them to seek advice from their own GPs. Not only were the opening hours beneficial to working age people, we considered it to be outstanding for this population group due to the additional service provided by the outreach work.

The practice made use of an alert system on the computerised patient records system to help them to identify patients who might be vulnerable or have specific

Good

Are services responsive to people's needs?

(for example, to feedback?)

needs This ensured that they were offered consultations or reviews where needed. The alert system also identified individual patient's risk to enable clinicians to consider issues for their consultations with patients, such as children who were known to be at risk of harm. This was also the case for patients who were caring for others as we have reported above.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the repeat prescription process was displayed in Slovak, Czech, Polish and Latvian in response to the recent increase in new Eastern European communities that now formed part of the local population. We learned that this had also supported greater understanding and expectations about antibiotic availability among recently settled people who had migrated from those countries where prescribing practices are different.

Additionally, although the practice had access to an interpreting service, we also saw that three of the GPs and two reception staff spoke Punjabi whilst one GP spoke Bengali and another GP spoke Arabic. Two staff had been provided with additional training to learn the basics of Polish to enable initial communication to take place with Polish patients. The practice web-site also had a translation facility.

The practice was in a recently built health centre. The premises and services had been adapted to meet the needs of people with disabilities. There was level access throughout, automatic doors, accessible toilets, a lift and an installed hearing loop in reception.

Access to the service

The practice offered two different types of service; a walk-in service for any person and a GP service for patients who were registered with the practice.

There were walk-in appointment slots between 8am and 8pm, seven days-a-week for any person who needed to see a clinician and who could attend the surgery, whether they were registered with this practice or elsewhere. These appointment slots were limited to consultations for minor illnesses only and could not be used by registered patients for their ongoing treatment; for example, treatment of long term conditions, medication reviews, blood tests, fit-for-work consultations and wound dressings. Walk-in appointments were held by a GP and an Advanced Nurse Practitioner (ANP).

The practice also had embargoed, GP appointment slots for its registered patients only that were released for booking on the day during the same hours, seven days-a-week. If any registered patient needed a consultation solely for a minor illness then they could make use of the walk-in service or take up one of the same-day appointments. A smaller number of appointments for registered patients only were available with GPs and with the nursing team that could also be pre-booked up to four weeks in advance. These appointment slots were for the ongoing management of patients' care and treatment such as long term conditions, medication reviews, nurse-led clinics and family planning. . We learned that when the new walk-in service was operating from the separate location in April 2015 it would continue to operate between 8am and 8pm whereas the scheduled appointments for registered patients would revert to being between 8am and 6:30pmfrom the practice's current location.

Patients could choose to see a male or female GP, even for same-day appointments, provided they were willing to be seen by any of the GPs on duty. We learned that patients who wished to see a particular, named GP would often have to wait for several days.

Registered patients who were too ill to come to the surgery or who were housebound were offered home visits and these were also booked over the telephone. Double appointments were available for people who needed them due to particularly complex conditions or if they were required to facilitate communication through an interpreter for example.

Access to appointments was usually by telephone but patients could also register to use the practice's online service to book appointments. Patients could also make use of a system called 'MJOG'. This was a mobile telephone texting service that enabled patients to use their mobile telephones to manage their appointments and prescriptions. The practice also offered telephone consultations every day and these, too, were available for booking on the day over the telephone for registered patients only.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The 2014 National Patient Survey results showed that patient satisfaction with the practice's opening hours and their experience of making an appointment was similar to other practices in England in the CCG area. For example, 79% of patients said it was easy to get through on the telephone, 83% said they were satisfied with the practice's opening hours and 83% said they could get an appointment to see or speak to someone last time they tried.

Patients we spoke with on the day of our inspection had no complaints about getting an appointment and told us they could always get to see a GP on the day if they needed to or revert to using the walk-in minor illness service.

A recurring observation from patients we spoke with and from the comment cards we reviewed was that they sometimes had to wait too long to be seen once they had made their appointment. This was borne out by the National Patient Survey data which showed that only 41% felt they don't normally have to wait too long to be seen; lower than the average for the rest of England.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was in line with recognised guidance and contractual obligations for GPs in England. The operations manager was the designated responsible person who handled all complaints in the practice. There was information on the practice web-site although this was limited to asking people to make a complaint in writing. There was no complaints leaflet available in the reception areas for patients to refer to.

All of the patients we spoke with said they had never had cause to complain but told us they would know how to complain if necessary.

We looked at the complaints received in the last 12 months and found that these were efficiently handled and dealt with in a timely way. All complaints were logged on an electronic database and an audit trail was kept of actions taken. A summary was compiled to enable the operations manager and the parent provider's head office to have an at-a-glance oversight and identify any themes. We noted that there had been 27 complaints in the period April 2013 to March 2014 and 12 complaints from April 2014 to the date of our inspection. All of the complaints, however, were relatively straightforward and learning from them was disseminated to staff members concerned. Any action arising from complaints was also taken, for example, we saw that the chairs in the waiting room had been replaced following a complaint that they were dirty.

Complaints were discussed at the monthly clinical team meetings and a summary was included in the monthly staff newsletter. Positive feedback was also included in the newsletter and communicated to individual staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice web-site carried the vision statement of the parent provider, One Medicare, in the form of a patient charter, the aim of which was to, 'Provide a modern, effective, caring service without losing the traditional concept of family medicine'. It was evident from our interviews with the management team, the GPs and the staff that the concept of a family GP that was available and accessible was one that was adopted and supported by everyone who worked there. We saw that the whole team understood the practice's aims and adopted a philosophy of care that put outcomes for patients first.

As reported above, we found that the practice had liaised with the clinical commissioning group (CCG) recently to help them to plan how they would deliver an additional walk-in service contract to the much larger population it would serve from April 2015 and this was one of the practice's principal strategic objectives at the time of our inspection.

Governance arrangements

The practice had a governance structure designed to provide assurance to patients and the CCG that the service was operating safely and effectively. The practice's monthly clinical management meetings provided clear direction and structure and enabled the practice to discuss a range of issues that affected its business, such as compliance with regulations, staffing and forward planning. There were identified lead roles for areas such as safeguarding, palliative care and minor surgery which were shared between the GPs. The practice had also identified areas of responsibility for other practice staff members. For example, one of the nursing team had lead responsibility for infection control and the senior advanced nurse practitioner (ANP) co-ordinated the delayed discharge initiative.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The practice also actively used the findings of significant event analyses, clinical audits and complaints to understand and manage any risks to their service through the monthly clinical management meetings.

There were clear policies for each aspect of the parent provider's and practice's business accessible to staff through the practice computer system and these were subject of periodic review to ensure they were up-to-date. However, some of the non-clinical policies had not been updated for more than two years, such as the data protection policy that was last updated in August 2012. The operations manager explained that she had been in discussions with the parent provider about the policies and that these would be updated. Staff were made aware of key policies during induction and could get access to clear instructions or protocols that set out how their work was to be performed.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice and the parent provider's vision of promoting a responsive and accessible service within the concept of a traditional family GP. The GPs and the operations manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. Staff we spoke with told us they felt confident they could raise any issues with the GPs or the management team.

The practice had good links with the CCG and this helped to ensure the needs and experiences of the population it served were used to develop the business and the practice culture of the staff.

There were robust policies in place that also had the practical effect of supporting staff. For example, we noted that there was a zero tolerance policy in place in relation to abuse or violence towards staff and this was overtly publicised in the practice and on the web-site. This demonstrated that staff safety and wellbeing was treated a priority by the practice.

Practice seeks and acts on feedback from users, public and staff

Until recently the practice had an active patient participation group (PPG), a group made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. The PPG had met face-to-face but also through exchange of views electronically in a format known as a 'virtual PPG'.

The PPG had been responsible for helping the practice to obtain and interpret the views of its patients, for example

Are services well-led?

Good

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

through two patient surveys of 2011 to 2012 and 2013 to 2014. These results of these surveys had been evaluated and had resulted in action being taken to improve the services. For example, the last PPG report of 2013 to 2014 showed that patients had asked, through the survey, for more pre-bookable appointments and for extra services to be provided. As a result, an ANP had been deployed to provide additional minor illness sessions including Saturday mornings and the practice had implemented a number of different extra services such as some additional family planning services and women's health checks.

However, at the time of our inspection the PPG membership had fallen due to a decrease in interest and there was now only one active member. The operations manager explained that, at the time of our inspection, they were seeking expressions of interest in order to reinvigorate this group and we saw that the practice web-site was being used to generate this interest.

The practice also acted on feedback and comments from patients. In the waiting area we noted a large, highly visible 'You said: We did' display that informed patients how their feedback had helped to tailor its services. For example, the display showed that the practice had responded to patient feedback by ensuring more same-day appointments were available and that easy-clean chairs had been installed in the waiting area.

The practice was seeking information from patients using the 'family and friends' test. This was by means of five lockable boxes into which patients could insert a green token to indicate their choice as to whether they would recommend the practice to others on a scale from 'definitely would' to 'definitely would not'. The outcome of this was not available at the time of our inspection although the early indications were that the majority of patients would definitely recommend the practice to others.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for further learning through specific, protected time allocated for it.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working.