Wonersh Surgery

Quality Report

The Surgery
The Street
Wonersh
Guildford
Surrey
GU5 0PE
Tel: 01483 898123
Website: www.wonershsurgery.nhs.uk

Date of inspection visit: 14 October 2014
Date of publication: 22/01/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Wonersh Surgery on the 14 October 2014.

The practice has an overall rating of good. Although some aspects of the practice required improvement.

Our key findings were as follows:

- All practice staff work to provide the best clinical care with significant emphasis in protecting the continuity of care for patients.
- Patient feedback about the practice and the care and treatment they received was very positive. A high percentage of patients felt they are treated with dignity and respect. This was evidenced from the national GP survey, the practice survey taken in 2014 and from patients we spoke with on the day of inspection.
- There are a range of appointments to suit most patients' needs. However, some patients reported difficulty in calling the practice to book appointments, accessing appointments on the same day or with their preferred GP.
- The practice is clean and tidy, with appropriate monitoring to minimise the risk of infections.
- Patients are well supported to manage their long term medical conditions. Patients with complex needs, living in care homes and those over 75 years have personalised care plans to facilitate a continuity of care and support from all health professionals.

We saw several areas of outstanding practice including:

- GPs who work in the practice regularly attend child protection case meetings and have continued engagement with local authority safeguarding teams.
- Patients with palliative care needs are supported using the Gold Standards Framework. The GPs of the practice often move beyond the requirements of the framework to support patients.

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

Importantly, the provider should:

- Undertake health checks for all patients with a learning disability on their practice register.

Summary of findings

- Review the disposal of sharps waste in the practice to ensure this meets with national waste regulations.
- Share successes and positive feedback from patients with staff.
- Provide feedback to patients who have made suggestions for improvements.
- Develop a strategic plan for the practice to include a focus in improving the operational leadership and enable the practice to remain efficient and responsive to patients' needs.
- Review their appointments system and telephone access to the practice in order to improve the patient experience.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned and communicated with staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Equipment was available for use in medical emergencies. There were systems to protect patients from the risk of abuse.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. The National Institute for Health and Care Excellence guidance was referenced and used routinely. Patient needs were assessed and care was planned and delivered in line with current legislation. This included the assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had undertaken appraisals. Multidisciplinary and collaborative working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Data from the latest national patient survey showed that 92% of patients rated their overall experience of the practice as good. The practice had a carers' register which identified patients who required additional emotional support. One GP in the practice was a chairman of a local community centre which offered support and respite to patients from the practice and others in the community.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. We found the practice had initiated positive service improvements for their patients that were often over and above their contractual obligations. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and clinical commissioning

Summary of findings

group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice. Some patients had a named GP for continuity of care, with urgent appointments available the same day. The practice premises were accessible and were well equipped to treat all patients and meet their needs. There was a well-advertised complaints process with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and patients.

Are services well-led?

Good

The practice is rated as good for well-led although some improvements were required. We found the practice was clinically well led with a core ethos to deliver the best quality clinical care and protect the continuity of care for patients. The practice did not have a documented overall vision and strategy. Some staff reported that the practice lacked leadership in strategic planning and felt this was needed to remain efficient and continually improve. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to support and guide staff with their duties. Regular meetings with different staff groups took place. Minutes of the meetings were shared with staff who were unable to attend the meeting. We reviewed the minutes from some of these meetings which were thorough and included actions to be taken. There were systems to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon in most cases. However, this was not always fed back to the patient or member of staff. The practice did not have an active patient participation group (PPG) but used a virtual group of patients to seek feedback about new developments or service changes. They were not significantly involved in the practice. Staff had received inductions, training, appraisals and attended staff meetings.

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 the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services. For example, in dementia care. The practice was responsive to the needs of older patients, including offering home visits and same day appointments for those with enhanced needs. Elderly patients with complex care needs all had personalised care plans that were shared with local organisations to facilitate the continuity of care.

The practice had safeguarding processes to protect vulnerable patients from abuse. Staff were aware of the process and were able to describe what action to take if they suspected abuse or had concerns. A chaperone service was available to all patients.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. When needed, longer appointments and home visits were available. All of these patients had a named GP and structured annual reviews to check whether their health and medicine needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Appropriate monitoring and reviews were undertaken to support patients with managing their conditions and preventing deterioration in their health.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems for identifying and following-up children who were at risk were not always followed. For example, there was no formal process for identifying children at risk who had failed to attend appointments. Immunisation rates were high for all standard childhood immunisations. In 2013/14 the practice immunisation rates for two year olds was 93% and five year olds 96%. This exceeded the national averages. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and additional flu clinics were arranged during school holidays. The premises were suitable for children and babies. We were provided with good examples of joint

Summary of findings

working with midwives and health visitors. There were emergency processes and referrals were made for children and pregnant women who had a sudden deterioration in health. The practice had safeguarding processes to protect children from abuse. Staff were aware of the process and were able to describe what action to take if they suspected abuse or had concerns.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). Their needs 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 which reflected the needs for this age group. In 2013/14, 89% of relevant female patients were screened for cervical cancer. Patients were able to book appointments from 8am and collect prescribed medicines from the neighbouring pharmacy, which also opened at 8am.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. For example, patients who were housebound or homeless. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. However, they had not always carried out their annual health checks. The practice offered longer appointments for patients with learning disabilities. Patients with no fixed abode were supported by the practice. They were able to use the practice address for their incoming mail from local hospitals, which they were able to collect at a time that suited them.

The practice worked closely with the district nurses, who were based in the practice. This enabled an improved continuity of care for their housebound patients. The practice regularly worked with multi-disciplinary teams in the case management of adults and children who were vulnerable. The practice had sign-posted these patients to various support groups and voluntary sector 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 and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). 97% of patients experiencing poor mental health had a comprehensive care plan and most of these patients had received appropriate health reviews. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had implemented advance care planning for patients with dementia. Staff had received training on how to care for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations. The practice also worked closely with the local mental health team and consultants. On occasion the practice hosted mental health team and consultant clinics at the practice, to facilitate easier patient access to the team.

The practice had safeguarding procedures to protect vulnerable adults, including those with poor mental health. A chaperone service was also available to all patients.

Summary of findings

What people who use the service say

We reviewed the results of the national patient survey from 2013 which contained the views of 124 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. Ninety three percent of patients confirmed the last appointment they had booked was convenient to them. However, the results for contacting the practice by phone to access appointments and feedback about the practice opening times were below the national average. The practice was considering how to address these issues.

The practice provided us with a copy of the practice patient survey results from 2014. Responses were received from 132 patients. Ninety three percent of patients felt the service provided by the nurses was good or very good. Ninety five percent of patients felt the GP explaining their medical condition and treatment was good or very good. Ninety two percent of patients felt the GP involved them in decisions about their care and treatment. Seventy seven percent of patients rated the care they received from the practice as good or very good.

We spoke with seven patients on the day of the inspection and reviewed 17 comment cards completed by patients in the two weeks before the inspection. Both the patients we spoke with and the comments we reviewed were positive and often described excellent care. Four of the patients we spoke with and one comment card gave negative feedback regarding access to appointments and telephoning the practice. We relayed these to the registered manager and practice manager.

Areas for improvement

Action the service SHOULD take to improve

- Undertake health checks for all patients with a learning disability on their practice register.
- Review the disposal of sharps waste in the practice to ensure this meets with national waste regulations.
- Share successes and positive feedback from patients with staff.
- Provide feedback to patients who have made suggestions for improvements.
- Develop a strategic plan for the practice to include a focus in developing an overall strategy and vision to enable the practice to remain efficient, effective and responsive to patients' needs.
- Review the appointments system and telephone access to the practice in order to improve the patient experience.

Outstanding practice

- GPs within the practice regularly attended child protection case meetings and had continued engagement with local authority safeguarding teams.
- Patients with palliative care needs were supported using the Gold Standards Framework. The GPs of the practice often moved beyond the requirements of the framework to support patients.

Wonersh Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspection Manager**.** The team included a GP and a practice manager specialist advisor.

Background to Wonersh Surgery

Wonersh Surgery offers primary medical services via a primary medical services (PMS) contract to the population of Wonersh and surrounding areas of Bramley, Shamley Green, Shalford, Albury and Peasmarsh. There are approximately 10,650 registered patients. The practice delivers services to a significantly higher number of patients who are aged 65 years and over, when compared with the local clinical commissioning group (CCG) and England average. Data available to the Care Quality Commission (CQC) shows fewer of the registered patients suffering income deprivation than both the local and national average.

Care and treatment is delivered by six GP partners and three salaried GPs. The practice also has two trainee doctors as they are a training practice. There are a mix of male and female GPs. The practice employs a team of three practice nurses and three healthcare assistants. GPs and nurses are supported by the practice manager and a team of reception and administration staff. The practice has not been subject to a previous inspection.

The practice takes an active role within the Guildford and Waverley CCG, with two of the GPs taking a lead role in supporting and developing new clinical pathways for mental health, cancer services and end of life.

Services are provided from:

Wonersh Surgery, The Surgery, The Street, Wonersh, Guildford, Surrey,GU5 0PE.

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

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 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.

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Guildford and Waverley Clinical Commissioning Group

Detailed findings

(CCG). We carried out an announced visit on 14 October 2014. During our visit we spoke with a range of staff, including GPs, practice nurses, health care assistants (HCAs) and administration staff.

We observed how patients were being cared for and talked with seven patients and reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 17 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

The practice population has a higher number of patients over 65 years of age than the national and local CCG average. There are a lower number of patients with long term health conditions. The number of patients between the ages of 20 and 34 years was also much lower than the England and local CCG average. The practice was situated in an affluent area of Surrey with lower rates of deprivation for children and older people. There were average numbers of patients who were registered as carers or who were living in nursing homes. A lower rate of prevalence was reported for patients with a mental health condition or dementia. The practice reported having small numbers of patients from vulnerable groups. For example patients with learning disabilities or those who had no fixed abode.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, from reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents. One member of staff described how they had previously identified concerns relating to a younger patient, with a GP in the practice. These concerns were raised before the patient had been seen for their appointment and meant these were reviewed by the GP and followed up appropriately.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months. Significant events were included on the practice meeting agenda in order to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reported events and issues were logged on a significant events log by the practice manager. The records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, a travel vaccination had been administered in error to two patients. Immediate action was taken to protect the safety of the patients and guidance was sought from vaccine specialists. The practice changed their processes for administering vaccines to adult and child patients and how these were being stored to prevent recurrence of a similar incident in the future.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us that alerts were shared and relevant action taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a dedicated GP lead for safeguarding vulnerable adults and children. All GPs had received level three training in child protection and we reviewed evidence to conclude this. Nursing staff had level two child protection training and reception and administration staff level one. All staff had received protecting vulnerable adults training appropriate to their role. We spoke with GPs, nurses, healthcare assistants, reception and administration staff about safeguarding. They could demonstrate they had received the necessary training to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. Contact details for local authority safeguarding teams were easily accessible in the consulting rooms and back offices of the practice.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, older patients with complex care needs, children and families affected by domestic abuse or looked after children. We spoke with the practice manager and registered manager about how the practice identified children or patients over 75 years, who failed to respond to vaccination invitations or attend appointments. They told us that staff would notify a GP of such a concern but there was no formal process for this to happen routinely. Staff we spoke with told us this was not something they regularly monitored or would always identify.

There was active and appropriate engagement in local safeguarding procedures and collaborative working with local authority teams. The lead GPs for safeguarding regularly attended safeguarding case conferences in relation to child protection and domestic violence cases.

A chaperone policy was in use, advertised on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones. All staff undertaking these duties had received a criminal records check through the Disclosure

and Barring Service. During the inspection, we asked seven patients whether they were aware of the chaperone service available to all patients of the practice. Only one patient was aware of the service.

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

Medicines Management

We checked medicines stored in the treatment rooms, medicine refrigerators and GP bags. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records to confirm this. The correct process was understood and followed by the practice staff, and they were aware of the action to take in the event of a potential failure.

The practice had processes 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.

There was a process for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. We noted that in 2013/14, 64% of patients had received a medicine review. We spoke with staff from two care homes where the residents were registered patients of the practice. They told us that the GPs were very proactive in reviewing the residents' medicines and this happened annually or as required. They also reported that changes to repeat medicines were made swiftly. Repeat prescriptions could be ordered online, in person or by telephone and were ready for collection within 48 hours or more urgently if required.

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 and kept securely at all times.

GPs carried out medicine reviews for patients who were prescribed repeat medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the medicines and documented any changes. One member of staff we spoke with supported the GPs in monitoring the practice prescribing patterns and budget. They told us that they regularly met with the clinical commissioning group prescribing lead to evaluate the prescribing rates of specific medicines. Where issues were identified this information was shared with the practice prescribing lead GP, who reviewed patients using this medicine. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules and that cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out infection control audits and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

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

On the day of inspection we found some sharps bins were not being used according to the current regulations for the disposal of sharps waste. We found one bin that was dated

Good

Are services safe?

2012 and had sharps waste and other medical equipment added to the bin. This demonstrated that staff were not always following the appropriate guidance or their own practice policy on the safe disposal of such waste. We spoke to the lead nurse who told us they had provided segregation of health care waste training and advice to all the GPs and nurses. The lead nurse took immediate corrective action to address the concerns identified.

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

The practice had a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. Remedial actions were required from the last Legionella audit and these had been completed.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was recorded. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment. For example weighing scales.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions.

Staffing & Recruitment

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

Staff told us there were always the correct number of staff and skill mix of staff needed to meet patients' needs. We saw there was a rota system for all the different staffing groups to ensure they were enough staff on duty. There was also a system for members of staff, including GPs, nursing and administrative staff to cover annual leave. Each GP had a buddy who they worked collaboratively with so that the continuity of care for patients was maintained. We spoke with staff from two care homes where the residents were registered patients of the practice. They told us that the buddy system worked well most of the time and the covering GP would be aware of each resident and their needs.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. In the last two years, the practice had increased the numbers of staff in the administration team to meet the growing demands of general practice.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies 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 at GP partners' meetings and within team meetings. For example, the practice nurse had shared the 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. Eleven percent of the practice population (those aged over 75 years) had a registered named GP. Two percent of elderly patients registered with the practice needed extra support. These patients were given high priority when they contacted the practice. Reception staff arranged with the named GP to call back the same day or if urgent the duty GP. These patients had personalised care plans to support the patients and health professionals with their specific care

needs. These included the support and care required when deterioration in health was detected. These plans were shared with local care services, including the local out of hours and ambulance service.

For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to the duty GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. 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). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction to a substance or material) and hypoglycaemia (low blood sugar levels). Processes were also used to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan had been developed to deal with a range of emergencies that may impact on the daily operation of the practice. Mitigating actions were recorded in order to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. Copies of the plans were available in the practice manager's office and two GPs also held copies offsite. Staff we spoke with new where to locate the plans in the event of an emergency.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training.

We spoke with nine members of staff during our inspection. One member of staff told us that they carried out the monthly tests on emergency lights and weekly fire alarm tests. All staff told us that they had received basic life support training. Some were able to explain what actions they needed to take when one of the emergency call buttons was used in the consulting rooms or within the practice computer system. They were also aware of the location of the accident book and the procedure to report these incidents.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The registered manager told us they and other GPs in the practice held lead roles in specialist clinical areas such as diabetes, chronic obstructive pulmonary disorder, mental health and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, the mental health lead supported all staff to continually review and discuss new best practice guidelines for the management of mental health conditions and dementia. The practice used a nationally recognised dementia test which was valid for patients aged 50-90 years old and was able to detect dementia at an early stage.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The registered manager told us that GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care for with suspected cancers were referred and seen within two weeks. National data showed the practice was making referrals to secondary care at a higher rate (12%) than other practices in the clinical commissioning group (CCG) area. The number of practice referrals, where the patient received a cancer diagnosis, was higher than the CCG and England averages. Multi-disciplinary meetings were held with other health professionals to support patients with a diagnosis, their families and carers.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice has a system for completing clinical audit cycles. The practice showed us six clinical audits that had been undertaken in the last year. The GPs told us clinical audits were often linked to safety alerts. For example, in May 2014 the Medicines and Healthcare Products Regulatory Agency issued a safety alert which recommended changes to the use of a specific medicine, in order to minimise risks of potentially serious effects on the heart. The practice undertook an audit review of patients who were taking this medicine and made changes to the doses taken and provided support in the management of the change. Other examples of clinical audits included those to confirm how many minor surgical procedures resulted in infections at the wound site. This audit was undertaken using guidance and research from National Institute for Health and Care Excellence. All the audits we reviewed were in mid process and had either been re-audited to monitor the results again after a set period of time or were planned in the next 12 months. On the day of inspection, we were unable to evidence a full audit cycle, learning and evaluation of audits provided by the practice.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF is a national performance measurement tool. For example, in 2012/13, 94.7% of patients with diabetes had their weight and body mass index measured in the previous 15 months. Ninety seven percent of patients experiencing poor mental health had a comprehensive care plan. Over 85% of these patients had received the appropriate reviews to measure their blood pressure, body mass index and measure alcohol consumption. The practice met all the minimum standards

Good

Are services effective?

(for example, treatment is effective)

for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease), epilepsy and chronic kidney disease. This practice was not an outlier for any QOF clinical targets.

The practice was making use of clinical meetings to assess the performance of the GPs and nurses. The GPs we spoke with discussed how as a group they reflected upon 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 GPs and nurses should undertake regular clinical audits.

Effective staffing

Practice staffing included GPs, 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. A good skill mix was noted amongst the GPs. One GP had additional qualifications in end of life care. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which training needs were documented. The practice had recently introduced a new system which offered e-learning training in all the mandatory training topics for all staff. For example, safeguarding, infection control and patient confidentiality. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with the lead nurse who told us the practice had always supported education. The nursing team were able to attend additional training in specialist areas such as diabetes management and asthma. Those nurses with extended roles had diplomas in the management of conditions such as chronic obstructive pulmonary disorder and heart failure. As the practice was a training practice, doctors who were in training saw patients during extended appointments and had access to the GP training lead throughout the day for support.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. All relevant staff were clear on their responsibilities for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. The practice had a policy for communicating with the out of hours service via a system of special notes.

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those with end of life care or a cancer diagnosis. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. A community matron also visited the practice on a weekly basis to discuss frail and elderly patients and provide support to the GPs. We spoke with one external health professional who explained that multi-disciplinary involvement from professionals and the patients in developing the specific care plans had ensured that patients from the practice received the best level of care in a consistent manner. We also spoke with a local care home. They told us the care plans for all their residents had been developed, were kept up to date and had made a real difference to the level and continuity of care.

GPs in the practice worked closely with the mental health team. We spoke with a member of staff from this team who confirmed that the practice worked collaboratively with the mental health consultant and they often held clinics at the practice, to facilitate appointments with patients. Local hospital consultants in urology, ophthalmology, ENT (ear, nose and throat) and minor operations held clinics so that patients could be seen at the practice. These clinics assisted patients by preventing them from having to travel to the main hospital.

The practice was not involved in shared care arrangements for patients with difficulties relating to substance addictions and misuse. However, the practice worked

collaboratively with a local drug and alcohol service to support patients with specific needs. One GP in the practice had, on a number of occasions, supported patients in the management of their care regimes in relation to their substance addictions and misuse.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were used to make referrals through the Choose and Book system. (The Choose and Book system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems available to provide staff with the information they needed. An electronic patient record was created within EMIS Web and was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. Another software product, DocMan, was integrated with EMIS Web and 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 most staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples of how a patient's best interests were taken into account if they did not have capacity to make decisions or understand information. We spoke with one nurse who was not clear on the principles or its application. Other staff reported that they had dementia training which briefly covered the Act. We found their understanding was limited.

Patients with more complex needs, those in care homes or 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). GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, written consent was taken for all minor surgical procedures. A patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

The practice offered all new patients registering with the practice a health check. GPs used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 or smoking advice to smokers. Self-testing chlamydia kits were also available to patients. One administrator in the practice ensured the computer system was up to date so review reminders for patients with long term conditions were flagged up to a GP at any consultation with the patient. This also allowed for opportunistic checks to be undertaken with the patient as part of their long term condition management and prevention of deterioration in health. The practice had active recall systems for asthma, chronic obstructive pulmonary disease, rheumatoid arthritis, thyroid, hypertension and stroke. There was a dedicated administrator to ensure patients were recalled for review at the appropriate intervals.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. However, we noted that the practice had not commenced annual checks for these patients. In 2012/13 the practice had also identified the smoking status of 83.3% of patients over the age of 16 and actively offered smoking cessation clinics to these patients. Ninety seven percent of these patients had been offered smoking cessation support which was above average compared to the local clinical commissioning group and national figures. The registered manager told us that the practice had achieved the highest number of validated quitters in the CCG area for 2013/14. Similar mechanisms of identifying at risk groups were used for patients who were obese or were carers. These groups were offered further support in line with their needs.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was 89% which was higher than the national average. The practice offered letter and telephone reminders for patients who did not attend for cervical smears and the practice reviewed patients who did not attend annually.

The practice offered a full range of immunisations for children, travel vaccines, flu, pneumococcal and shingles vaccinations in line with current national guidance. Last year the practice increased their immunisation rates for two year olds to 93% and five year olds to 96%. This was a result of moving the recall service into the practice from an external provider. In 2012/13 the practice immunised 90.2% of appropriate patients with the influenza vaccine. This was lower than the CCG average of 94.4%. District nurses provided influenza vaccines to housebound patients or those who found it difficult to get to the practice. This included any carers and relatives living with these patients.

In addition, health promotion and prevention support was offered in the following ways. The practice undertook cognitive assessments to detect possible or early signs of dementia. A dietician held clinics for diabetic patients. The practice has regular family planning clinics, which included advice, support and treatment for a variety of contraceptives. The GPs also provide contraception advice and treatment for younger patients. The practice worked closely with a local school and health promotion leaflets were provided. A sexual health clinic was held at the school regularly.

We noted that a wide range of health promotion information was available in leaflets in the waiting rooms and on the practice website. Such information was also given to patients during consultations and clinics.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 92% of patients rated their overall experience of the practice as good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. Ninety seven percent of patients had confidence and trust in their GP with 95% of respondents saying the GP was good at listening to them and 90% saying the GP gave them enough time.

We also reviewed a practice patient survey from 2014. Ninety three percent rated the service from the nurses as being good or very good. Ninety five percent of patients described that their GP was good at listening to them. We asked the same questions to patients on the day of inspection and they all responded positively.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 17 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. One patient was less positive but there was no common theme to this. We also spoke with seven patients on the day of our inspection. They all told us that 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. Curtains or screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk in a back office which helped keep patient information private. We noted a system had been introduced to allow only one patient at a time to approach the reception desk. This minimised the risk of patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. On the day of inspection we noted the door between the reception area and waiting room was closed to promote further privacy. However, patients and staff we spoke with reported that the door was normally open.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

All staff in the practice had received dementia training. This allowed staff to understand the needs and communication difficulties that could arise for patients with this condition. The training provided staff with the skills to identify these concerns and also support the person in alternative ways.

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 patients said the GP involved them in care decisions and 84% felt the GP was good at explaining treatment and results. We also reviewed the practice survey from 2014 and 92% of patients agreed that their GP involving them in decisions about their care and treatment was good or very good.

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 were given appropriate time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported 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 and on the practice website. The practice website also had the functionality to translate the practice information into approximately fifty different languages.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations. The practice computer system alerted GPs if a patient was also a carer. We saw written information available for carers to ensure they understood the various avenues of support available to them. The practice had a register of patients who were carers. One GP had a particular interest in supporting carers. They were the chairman of a community day centre, which provided respite for carers and supported elderly patients one day a week with a meal and social event.

Eighty eight per cent of patients who completed the national survey said GPs treated them with care and concern. This result compared favourably with other practices locally. We spoke with some parents of young children. They told us the GPs and nurses were very caring towards their children and involved the child, when possible, in discussions about their care and treatment.

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 patients' needs and they understood their patient population. The NHS Local Area Team (LAT) 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.

There had been very little turnover of staff during the last three years which enabled a continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and for those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one. We spoke with staff from these homes who were very positive about the care and support from the practice and named GPs. They explained that the GPs were very responsive to concerns raised about the patients who lived in these homes, attending urgent calls in a timely manner. They also described how changes to care and treatment were actioned immediately.

The practice provided care and treatment for children with behavioural problems at two local homes. They had a dedicated GP to ensure a continuity of care, which was essential for these patients.

GPs of the practice also undertook approximately 30 home visits each week for their registered patients. These visits were usually undertaken by the patients named GP.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the GP national patient survey. We saw an action plan which highlighted eight areas of improvement. The practice had changed the appointment system to facilitate quicker appointments for routine ailments. An education process had ensured information was available and provided to patients to promote the use of telephone appointments. Information leaflets about the appointment system in the practice had also been produced and were available in the practice waiting rooms. At the time of inspection we reviewed the actions and nearly all had been completed.

The practice had achieved and implemented the Gold Standards Framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. The GPs of the practice regularly moved beyond the framework to support patients. For example, by providing proactive, personal planned care from the time of referral with suspected cancer, through engagement with the hospital multi-disciplinary team during the active treatment phase and personal palliative care in liaison with specialist nursing and the hospice team.

New mothers were supported by a midwife who provided two clinics a week at the practice. The midwife had a shared care arrangement with the GPs. Pre and post natal care was provided and the GPs visited new mothers and their babies at home for a 10 day and an eight week check.

A health visitor clinic was held weekly at the same time as the baby clinic, to save patients time. The health visitor carried out a six week check and a one year review. They also liaised with GPs and secondary care teams.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

Families with children and young people were supported by the practice. For example, additional Flu vaccination clinics were available during school holidays for children. Sexual health clinics were held at local schools and one school had a named GP for all the pupils.

Working age patients were able to book appointments and order repeat prescriptions on line. The practice and neighbouring pharmacy opened at 8am for working aged patients to have early appointments and obtain medicines before leaving the practice.

Patients experiencing poor mental health were supported by the GPs and a local mental health consultant. Patients were sometimes able to attend consultant appointments at the practice when they hosted clinics. Staff told us that patients attending the practice who were experiencing mental distress could be seated in a private room or waiting area, if this made them feel more comfortable. The GPs were able to refer patients to local counselling services and the 'Improving Access to Psychological Therapies' team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were supported. The practice told us that patients with no fixed abode could register and be treated at the practice. They told us that these patients were able to use the practice address for mail from the local hospital and could collect this at any time during opening hours.

The practice provided equality and diversity training via e-learning. The practice patient charter stated that 'all patients will be treated with respect, kindness and dignity, irrespective of ethnic origin, cultural beliefs, gender, age, social class, religion, sexual orientation, appearance, disability or medical condition.' The evidence we found on the day of inspection supported this statement.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was situated in an old listed building but had reasonable access for disabled patients. There were consultation rooms on two floors and patients with mobility difficulties were seen by the GP in a ground floor room.

We noted that access to the front entrance to the practice could be difficult for patients with disabilities or mobility difficulties. There were single width doors which did not have an automatic opening mechanism. There were also cobbled pathways from the car park. The practice had risk assessed these concerns and had provided an alternative entrance to the rear of the practice. A wider disabled parking bay and drop off point was available immediately beside a ramped entrance to the practice. Patients with a disability could easily enter the practice and had level access to reception, waiting areas and consultation rooms on the ground floor. The corridors, waiting and reception area all were accessible for wheelchairs and mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

The practice manager and a GP told the CQC GP specialist advisor that they had explored the possibility of installing a lift within the premises which would provide patient access to the first floor GP consulting rooms. However, the layout and listing of the building had prevented this. The practice ensured that patients who needed to be seen in ground floor consulting rooms were accommodated in order that they were able to see their preferred GP.

The reception desk was also lowered at one end so reception staff could speak easily with all patients. Accessible toilet facilities were available. A hearing loop was in use in reception to support patients with a hearing impairment.

Access to the service

Appointments were available from 8am to 6pm on weekdays. The practice was closed daily between 12:30pm and 1:30pm. We were unable to see clear evidence to confirm how patients could access primary care services during this time. At the time of inspection there was not clear information advertised in the practice, on the practice website, in the patient leaflet and on the appointments brochure in the waiting room.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed at weekends, after 6:30pm Monday to Friday and on bank holidays. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the Out of Hours service was provided to patients on the website, practice leaflet and appointment information advertised in the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent and routine appointments, telephone consultations and home visits and how to book appointments through the website. The online booking system had improved the experience of booking appointments for patients of working age.

Patients were generally satisfied with the appointments system. Most confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. The results from the last patient survey indicated that 92% of patients were able to get an appointment when they last tried and 92% were satisfied the appointment was convenient to them. However, on the day of inspection two patients told us that it was not easy to get an appointment with some GPs. Staff also told us they frequently received feedback from patients that they were not happy with the appointment availability or length of time they had to wait. The patient survey also indicated that only 63% of patients found it easy to get through on the telephone. This was also reported to us on some of the comments cards that had been completed by patients, expressed to us by

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients we spoke with and by staff on the day of inspection. We spoke with the practice about these concerns. They had developed an action plan to address the concerns of the minority of patients and actions had been taken improve the access to appointments and the telephone system. For example, the practice had recently introduced 48 hour appointment slots for patients to reduce the waiting times for patients.

On the day of inspection we reviewed the availability of appointments for two GPs, for a blood test and also cervical screening. We found that all patients who had called for an urgent appointment that day had been offered an appointment that day or a telephone consultation. The next available appointment for one of the part time GPs was six weeks later. Another part time GP had appointments available two days later. This demonstrated how patients could obtain routine appointments with any GP within 48 hours on the day of inspection. We also looked at the next available appointments for routine and fasting blood tests. The next dates available were two or three days later. We noted that the next cervical screening appointment with the nurse was not available until over five weeks later. We spoke to the reception team and practice manager about this waiting time. They confirmed that the practice had lost two nurses recently, which had impacted on the availability of appointments for patients. The practice was in the process of recruiting replacement nursing staff and were awaiting the appropriate recruitment checks to be returned.

Comments received from patients showed that those in urgent need of treatment had always been able to make appointments on the same day of contacting the practice. One patient we spoke with told us how they often needed an urgent appointment due to a specific medical condition and they were always seen on the same day.

The practice had access to online and telephone translation services for patients whose language was not English. Patients who had difficulty in travelling to the practice were able to access a local charity. Volunteers provided transport services to take patients to the practice for their appointments.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were posters in the waiting rooms to describe the process should a patient wish to make a compliment, suggestion or complaint. Information was also advertised in the practice leaflet and website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at the complaints log for those received in the last twelve months and found these were all discussed, reviewed, learning points noted and shared at clinical and practice meetings. The practice reviewed complaints on an annual basis to detect themes or trends. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of 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 was clinically well led with a core ethos to deliver the best quality clinical care in a timely manner, whilst maintaining a high level of continuity. This was evident from our discussions with GPs and staff. However, the practice did not have a documented overall vision and strategy. We noted from the GPs we spoke with that there was a desire to develop an overall strategy for the business but there was no lead to take this forward. Some of the staff we spoke with reported that the senior team now needed a lead to provide the practice with direction and vision, in order to remain efficient, manage the challenges and continually improve.

The practice mission statement and values were clearly displayed in the waiting areas. The practice vision and values included offering a friendly, caring and quality service that was accessible to all patients and all patients would be treated with respect, kindness and dignity.

Governance Arrangements

The practice had developed a number of policies and procedures to support and guide staff. For example, in health and safety, disciplinary procedures, infection control, safeguarding and patient confidentiality. These were available to staff via the desktop on any computer within the practice. We reviewed a selection of policies and procedures and these had been reviewed annually and were up to date.

The practice held regular clinical meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. The practice had recognised that some part time GPs were not always able to attend these meetings and a plan was being considered for additional clinical meetings so all the GPs could attend more often. Significant events were shared with the practice team to ensure lessons were learned and prevent reoccurrence. GPs led on specific areas of clinical management for example diabetes, mental health and end of life. Others took lead roles in operational areas such as information governance and safeguarding.

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

The practice manager told us that the practice bench marked practice performance against clinical commissioning group achievement and this was used to inform service developments and changes in the practice.

The practice had completed a number of clinical audits. For example, the practice undertook a clinical audit to review urinary tract infections, currently prescribed pain relief and the impact of using a tool called the analgesic ladder. (A tool for clinicians to measure a patient's pain and prescribe the appropriate medicines according to their level of pain.) Changes from the audit were implemented and there was a plan to re audit after 12 months.

There were robust arrangements for identifying, recording and managing risks. The practice manager showed us how they managed risk for a wide range of issues to protect patients and staff. For example, risk assessments identifying which staff required criminal records checks to protect vulnerable patients and an assessment of risk for patients with complex needs. The practice also undertook risk assessments for fire, emergency equipment and medicines, oxygen and the storage of liquid nitrogen. We saw that risk assessments and actions were regularly discussed at team meetings and changes implemented in a timely way.

Leadership, openness and transparency

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

We saw from minutes that clinical team meetings were held weekly. 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. Administration and reception staff told us that they met in their teams but this was sometime on an ad hoc basis. They explained that

Are services well-led?

Good

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

when they were unable to attend their manager ensured that minutes of the meetings were circulated. Despite the lack of meetings, all of the staff we spoke with reported that communication was good in the practice and they were always made aware of new developments and changes.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies to support and guide staff. These were reviewed regularly and up to date. We were shown the electronic staff handbook that was available to all staff, this included sections on equality, harassment and bullying at work and whistle blowing. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, a suggestion box and compliments and complaints received. We looked at the results of the annual practice patient survey from 2014, where 132 responses were received. The results of the survey were advertised on the practice website. Only 13.5% of patients were able to book an appointment within a couple of days. Other patients requested that being able to book a non-urgent appointment within 48 hours would improve the length of time they sometimes had to wait. We saw as a result of this the practice had introduced a new system where a percentage of 48 hour appointments were released on a daily basis. The survey also showed that 33% of patients were unaware that telephone consultations could be requested. The practice manager showed us how they had improved the advertising of appointments on the waiting room notice boards, information leaflets and on the practice website. Of the seven patients we spoke with on the day of inspection they all knew that telephone consultations existed. Two of the patients had used the service and were satisfied with the outcome and efficiency of their calls with the GP.

The practice did not have an active patient participation group (PPG). However, the practice had a virtual group of patients, which had increased to 50 patients. The virtual group contained representatives from various population groups, including older patients. The practice manager had used the group to request feedback and support about changes in the practice but often received a very poor response.

A suggestions, compliments and complaints box was held in reception and the practice manager reported that they had received a number of responses from patients. We reviewed the information submitted. Some of the feedback was compliments about the staff and service. There were also suggestions for improvements. We noted that the practice had taken action to address some of these issues and make improvements. However, the practice had not shared this with the patient raising the suggestion.

The practice had gathered feedback from staff through staff meetings, discussions and surveys. Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management. Most staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. However, two members of staff reported that they had offered suggestions for improvements or changes to processes but these had not been considered or taken forward. This had discouraged them from making further suggestions and they did not always feel listened to.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We spoke with nine staff and they confirmed that regular appraisals took place which identified training. Staff told us that the practice was very supportive of training and education. The practice had recently implemented an e-learning training facility for all staff. On the day of inspection the practice had closed for half a day to allow staff to undertake modules of the online training. Nursing staff reported that the training available in order for them to maintain their skills was excellent and they were well supported to attend training events. The practice had a training policy to support all levels of staff.

The practice was a GP training practice and supported new registrar doctors in training. At the time of inspection there were two doctors who were receiving general practice training. The doctors held surgeries, made home visits,

Are services well-led?

Good

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

helped during clinics and supported the emergency rota. One of the GP partners supervised the doctors at all times. Occasionally, the practice also taught medical and nursing students.

The practice had completed reviews of significant events and other incidents. These were shared with staff via meetings to ensure the practice improved outcomes for patients. For example, an incident had occurred in relation to the fitting of a contraceptive device. The patient was immediately contacted, offered a course of treatment and invited back for another appointment. The practice investigated the incident. The lessons learned and actions taken were recorded and shared with the relevant staff. The patient was promptly advised by letter of the findings of the investigation.