Dr S Ahmed & Dr H Duffy

Quality Report

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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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection on 12th November 2014. We spoke with patients, members of the Patient Participation Group (PPG), and staff including the management team.

The practice is rated as Good. A safe, caring, effective, responsive and well-led service is provided that meets the needs of the population it serves.

Our key findings were as follows:

- The service is safe. All staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents are maximised to support improvement.
- The service is effective. The practice is using proactive methods to improve patient outcomes and it links with other local providers to share best practice.
- The practice is caring. Patients told us they are treated with compassion, dignity and respect and they are involved in care and treatment decisions. Accessible information is provided to help patients understand the care available to them.
- The practice is responsive to patient's needs. The practice implements suggestions for improvements and makes changes to the way it delivers services as a consequence of feedback directly from patients and from the Patient Participation Group (PPG). Patients told us they are fully dated with the planned merger of the practice and have been asked for their comments.
- The practice is well-led. They have a clear vision which has quality and safety as its top priority. A business plan is in place that includes detailed plans for the forthcoming merger with another practice. This plan is monitored and regularly reviewed by both practices, and discussed with all staff. Cross practice working is already in progress to ensure both patients and staff from both practices are familiar with each other. High standards are promoted and owned by all practice staff with evidence of team working across all roles.

Summary of findings

We saw several areas of outstanding practice including:

- All the practice staff proactively followed up information received about vulnerable patients. .
- The approach of the practice in responding to and meeting the needs of different groups of people, including those in vulnerable circumstances or those with learning disabilities.
- The approach staff took to ensure patients were involved in the planning of their care and in decisions about their care / treatment using a variety of different methods appropriate to the person.
- The practice has close working relationships with the police and other protective agencies and was able to act quickly and address situations whilst maintaining the safety of the patient.
- The practice business plan for the future included a planned merger with another local GP practice; this was being handled in a sensitive, effective and open manner.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good 

The practice is rated as good for providing safe services. Safety within the practice was monitored and ways to improve were identified. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were discussed to support improvement. Information about safety was highly valued and also used to promote learning and improvement. Risk management was embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Good 

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We were able to discuss with staff how these guidelines were influencing and improving practice and outcomes for their patients.

The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good 

The practice is rated as good for providing caring services. 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. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Accessible information was provided to help patients understand the care available to them.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations.

The practice responded in an effective and timely manner to patients needs and were proactive in ensuring patients were removed from risk whenever this was identified. The practice had established close links and relationships with external agencies to support their delivery of prompt action.

Summary of findings

The practice was currently managing a merger with another practice. Patients and staff told us they had been fully involved in this and were aware of the progress. They told us their comments had been taken into account during this process.

Patients reported excellent access to the practice, with telephone and face to face appointments always available on the day or within 24hours of the request. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision which had quality and safety as its top priority, this vision was endorsed by the GP and practice manager and all staff we spoke with .

A business plan was in place which included the practice merger. It was monitored and regularly reviewed by both practices and discussed with all staff. We found there was a high level of constructive staff and patient engagement and a high level of staff satisfaction, with this process.

The practice sought feedback from patients and had an active Patient Participation Group (PPG).

High standards were promoted and owned by all practice staff with evidence of team working across all roles.

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.

Patients at the practice who were at risk of an unplanned hospital admission, of which there were 109, had a care plan in place. Housebound patients were routinely visited so they could be given information and advice to prevent hospital admissions.

The practice worked collaboratively as part of a multi-disciplinary team to take a holistic approach to caring for the over 65 age group. Regular meetings were held with other professional groups to discuss this group of patients and their needs.

At the time of the inspection there was only one permanent GP at the practice and he was the named GP for all patients over 75 years of age.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions.

Patients had as a minimum an annual review of their condition and their medication needs were checked at this time. When needed, longer appointments and home visits were available.

Patients at risk of being admitted to hospital due to their condition had a care plan in place, this was regularly reviewed by the GP and the multidisciplinary team involved in their care.

Patients who had been discharged from hospital with Do Not Attempt Resuscitation (DNAR) orders were visited as soon as practicable by the GP and the requests were discussed with patients and their family if the patient agreed in their home to ensure this was still their wish.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Staff knew their patient population very well and we saw a system in place to identify children or parents at risk. We also saw an example where a patient at risk had been protected.

Children and young people were treated in an age appropriate way and their consent to treatment using appropriate methods was requested.

Summary of findings

Childhood immunisations were carried out at the practice. Staff were able to promptly recognise signs of deteriorating health in young patients waiting in the practice and during the inspection we observed two young children being urgently transferred to the local A&E for immediate treatment. All staff were aware of the process to follow and promptly notified the GP and nurses of the need for immediate attention.

We were provided with good examples of joint working with professionals from other practices and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students.

Appointments were offered until 8pm on Monday evening. Telephone calls to patients who were at work were made at times convenient to them.

NHS Health Checks were offered to all patients between the ages of 40 and 74. This was an opportunity to discuss any concerns the patients had and identify early signs of medical conditions.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

All the staff at the practice, including the receptionists, were proactive and innovative when following up information received about their patients, specifically those who were vulnerable. The staff knew all the practice patients well and were able to identify a person in crisis. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies both in and out of hours. Staff had extensive links with local organisations to assist them in providing effective and timely support as required.

The practice held a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities (LD). The practice offered longer appointments for people with learning disabilities and carried out joint reviews with the patients, their families, carers and Community LD specialist team on a quarterly basis to address, adapt and monitor the care plans in place for this group of patients.

Summary of findings

When vulnerable female patients attended for intimate examinations staff used pictorial processes to gain consent and inform the patient of the procedure.

There was a local homeless shelter close to the practice and all patients at the shelter registered with the practice when they were first moved in. Patients continued their registration with the practice when they moved to a more permanent location unless they moved out of area.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice was rated as outstanding for the population group of people experiencing poor mental health including people with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups, and they were proactive in helping patients address issues to improve all aspects of their health.

Home visits for patients suffering with dementia related conditions were carried out on a monthly basis to monitor and support patients and carers with the condition.

The practice worked closely with a local mental health rehabilitation centre and offered support to patients who resided here. Patients were offered longer appointments as required and were always seen on the day they requested appointment. The practice had a mobile telephone that was given specifically to patients who had a mental health need to ensure they could always access support from the practice.

Summary of findings

What people who use the service say

We spoke with eight patients and the chairperson of the Patient Participation Group (PPG).

The patients we spoke with said they were very happy with the service they received. They all told us they spoke to a medical professional on the same day they made contact with the practice, and appointments were made if required. They told us there was sometimes a difficulty getting through to the practice by telephone but were aware the practice was trying to address this.

They also told us they could request an appointment with a GP or nurse of their choice. When asked patients did not identify any problems with confidentiality at the reception desk. However, they were aware there was a private room available if they wanted to speak in confidence with a receptionist.

Patients told us chaperones were always brought into the room during examinations, and they said there were notices in consultation rooms telling them that chaperones were available.

The patients we spoke with told us they were routinely asked for their opinion after consultations. They said they thought this was so improvements could be made. They said staff were helpful and treated them with dignity and respect.

We were told that the GPs, nurses and reception staff explained processes and procedures in great detail and were always available for follow up help and advice. They said they were given printed information when this was appropriate.

Patients we asked told us they were not concerned that there was no female GP at present within the practice as they were comfortable with the GP and had been with the practice for many years. They told us they could always see the nurse instead if they wished.

The practice had future plans to amalgamate with a neighbouring practice and patients told us they had been involved in the decisions made regarding this. The patients we spoke with were aware of where the practice was in this process and the changes that would effect them.

A PPG was in place. This group was a way for patients and the GPs to listen to each other and work together to improve services, promote health and improve the quality of care. The PPG was run in collaboration with the intended merger practice to ensure patients at both practice had the same information. Most patients told us they were aware of the PPG.

Outstanding practice

All the practice staff proactively followed up information received about vulnerable patients.

We discussed examples where clinical and reception staff had used their in depth knowledge of patients and their families and had raised a concern or passed on information which had led to a positive outcome for the patient.

The practice has a close working relationship with the police and other protective agencies and was able to act quickly and address situations whilst maintaining the safety of the patient.

We were informed of a situation where a patient with learning disabilities had requested an appointment with a member of staff and went on to discuss a situation that required immediate intervention. This was dealt with in a timely manner whilst protecting the patient.

The practice business plan for the future included a planned merger with another local GP practice; this was being handled in a sensitive, effective and open manner. We were told by staff and patients that they were fully aware of where the process was up to and had been fully consulted throughout. They all felt their opinions and comments had been listened to and where possible addressed. Joint working plans were already in progress and governance, quality, significant event analysis and

Summary of findings

PPG meetings were now shared meetings across both practices. GPs had started working across both practices to allow patients to become familiar with them before the merger.

Dr S Ahmed & Dr H Duffy

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an expert by experience.

Background to Dr S Ahmed & Dr H Duffy

Dr S Ahmed's practice is currently a single handed practice following the departure of a partner in recent months. The practice has decided to merge with another practice in the same building which they already have close working relationships with. This will be completed in April 2015. They share a Patient Participation Group (PPG) and have implemented cross practice working to ensure staff and patients are familiar with staff from both practices.

The practice currently had one male GP and had access to four locum GPs from the neighbouring practice to meet the needs of the 5300 patients who were registered with the practice. This was supported by an advanced nurse practitioner, three practice nurses, a practice manager, a medicine manager and a reception and administration team who were all very familiar with their patients.

The practice do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the surgery is closed at the weekends. The practice also used an acute visiting service from the local OOHs service for patients requiring immediate attention from a GP during surgery hours; this ensured patient's needs were immediately addressed without having to wait for the GP to visit after his surgery.

The practice population groups are in line with or slightly below National averages with some group just above CCG averages. The largest population group within the practice the 14-18 age groups, with over 85 being the smallest group at 2.3%. Both figures are in line with CCG averages.

63.8% of patients have a long standing health condition and 0.5% of all patients are resident in nursing homes. 7.2% of all patients are unemployed at the practice which is in line with CCG but higher than National average. 15.5% of patients have carer responsibilities.

The practice is at fourth more deprived percentile. Information published by Public Health England rates the level of deprivation as four on a scale of one to ten. Level one represents the highest levels of deprivation and ten the lowest. Income deprivation affecting older people is higher in the practice than National average at 21% but below the CCQ average. Whilst the income deprivation affecting children is below both the CCG average and the national average at 21%..

Ethnic estimation is 3.0% non-white ethnic groups

Male life expectancy 74.9 years, with female 80.4 years.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them

Detailed findings

How we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 November 2014. During our visit we spoke with a range of staff including the GP, locum GP, Advanced Nurse Practitioner, nurses, practice manager, medicines manager and the administration and reception team. We spoke with eight patients who used the service and the chairperson of the Patient Participation Group (PPG).

We observed how staff interacted with patients, carers and/or family members.

Good

Are services safe?

Our findings

Safe track record

The quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting incidents. We reviewed records and for example saw that the practice's training policy had been regularly reviewed and was next due a review in December 2015 or sooner should there be updates to staff's professional training requirements. We saw that all staff had been trained to at least a minimum level of basic life support.

In the period between April 2014 and the inspection a new process for reporting significant events had been implemented. We saw these events were discussed at the joint GP practice governance meetings and all staff updated where changes in practice were to be made. There were no identified themes or patterns to these events, which were all unrelated. These included clinical and non-clinical issues. We saw each incident had been analysed to consider what had occurred and why, what lessons had been learnt and whether there were measures that could be put in place to prevent future recurrence.

There were mechanisms in place for the prompt management of safety alerts and the medicines manager identified the alerts requiring further action and sent these through to the relevant professional to action. We tracked two recent alerts that had been received and found they had been accurately actioned.

We saw that that any complaints once investigated were analysed, summarised and reviewed to identify trends or recurrent risks. All actions from complaints were shared with staff and the PPG as appropriate.

Appropriate arrangements were in place with the building maintenance team for the maintenance of the building. Fire alarms and extinguishers were placed throughout the building. The fire exits were well signposted and free from hazards to prevent escape in an emergency. Alarms were tested weekly and the fire systems had been fully serviced. Fire training was up to date and we as a team were subject to a fire induction on arrival in the building.

The practice manager was new to post, and was aware of their responsibilities to notify the Care Quality Commission (CQC) about certain events, such as occurrences that would seriously affect the practice's ability to provide care.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. We found that staff actively reported any incidents and viewed this process in positive way to ensure they provided a high standard of patient care.

Significant events that we reviewed showed the date the event was discussed; a description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. We saw evidence that changes in practice had been applied. For example a change in risk assessment protocol for the prescribing of Diazepam had been implemented following a significant event and complaint.

We found any changes to national guidelines, practitioner's guidance and any medicines alerts were discussed and that staff met on a regular basis. Staff confirmed these meetings took place. This information sharing meant the GPs, nurses and non-clinical staff were confident the treatment approaches adopted followed best practice.

We saw that practice meetings, governance and quality meetings were now held cross practice with the practice involved in the merger, these were recorded.

Reliable safety systems and processes including safeguarding

All the staff at the practice, including the receptionists, were proactive and innovative when following up information received about their patients, specifically those who were vulnerable. The staff knew the patients well and were able to identify a person in crisis. Staff had an awareness of how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies both in and out of hours. Staff had extensive links with local organisations to assist them in providing effective and timely support as required.

Safeguarding policies and procedures for children and vulnerable adults were up to date and staff knew where to locate them. There was also access to local council policies and procedures and a matrix for escalation with contact names and numbers for each different safeguarding incident.

The GP and one practice nurse who were both trained to level 3 shared the responsibility of the safeguarding lead for

the practice and attended safeguarding meetings as requested. All clinical staff had completed adult safeguarding and child safeguarding to level 2 and were updated on a three yearly basis. The nurse who led on safeguarding had also attended a domestic violence training session.

The lead nurse for safeguarding had close links with other agencies should she require assistance to protect a patient registered with the practice. She was able to discuss recent incidents where the practice had secured the safety of children thought to be in need following observations by the practice staff. The practice had a walkie talkie link with the local police for immediate support with any incidents.

We saw two recent examples whereby a person in vulnerable circumstances had been identified and saw how staff had intervened to provide help, arranged appointments and liaised with the police and other health and social care professionals to assist the patient.

We were informed how links with other local organisations had assisted the practice to support vulnerable adults to access a place of safety. These links were maintained by regular phone conversations and sharing of appropriate information on new services.

The practice held a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities (LD). The practice offered longer appointments for people with learning disabilities and carried out joint reviews with the patients, their families, carers and Community LD specialist team on a quarterly basis to address, adapt and monitor the care plans in place for this group of patients using the Cardiff Health Check template.

There was a local homeless shelter located near the practice and people accessing this facility were registered with the practice for their health needs. The manager of the service, who was also a patient at the practice, actively encouraged people to visit the practice for support with their needs.

The safeguarding records and register at the practice were updated as a minimum on a monthly basis following discussion/ meeting with the GP and other professionals involved in the care. The practice was able to inform us of the number of children and vulnerable adults currently on their register and where they were in the process.

We were shown a book which was stored securely where staff could record observations regarding the behaviour or manner of patients who were thought to be vulnerable. These observations were brought to the attention of the nurse immediately by email alert asking them to come to reception to discuss the matter. The nurse would then see the patient as a matter of urgency to address the issue where possible or to offer alternative support.

Staff were trained to undertake chaperoning procedures as per the practice policy. Details about chaperone facilities were seen in the waiting room and consultation/treatment rooms. Patients told us they were offered the use of a chaperone where appropriate.

Medicines management

We saw that medicines management was supported by an appropriately trained member of staff. The process was supported by the local Clinical Commissioning Group (CCG) medicines management team who visited the practice on a monthly basis. We saw that audits were carried out by the CCG Medicines Management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions.

The practice had carried out an audit on patients taking Domperidone and had identified eight patients who had been reviewed by the GP. This was re-audited during the inspection and found there were now no patients taking Domperidone. We were shown two completed medicine audit cycles where changes had been made.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available within each clinic and treatment room. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. We found the practice had a defibrillator available and access to oxygen for use in emergency.

There was a clear policy for maintenance of the cold chain with actions to be taken in the event of any potential failure. No controlled drugs were kept on site.

The practice had a protocol for repeat prescribing which was in line with GMC guidelines. This covered how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. There was a system for reviewing patient's repeat medicines to ensure it was still safe and necessary. Only two members of staff were able to prescribe medicines and this included the GP and the advanced nurse practitioner (ANP) The practice

processed repeat prescriptions within 48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs.

We were shown the practice protocol for Disease-Modifying Antirheumatic Drugs (DMARDs) which are a group of medicines that are used to ease the symptoms of rheumatoid arthritis (RA) and reduce the damaging effect of the disease on the joints. The medicine manager reviewed the patient records on DMARD's and patients who are on specific anti-coagulation medication requiring regular blood tests every month to check they were in line with good practice. She then forwarded these patient details to the ANP and nurses to book regular reviews and followed them up if necessary. All patients who were taking anticoagulation medicines were seen by the anticoagulant team who were located within the health centre for their blood testing.

Medicine reviews were conducted by the GP, Advanced Nurse Practitioner (ANP) and the nursing team.

Security measures were in place for prescriptions access. When making home visits, the GP and ANP took suitable precautions to prevent the loss or theft of forms, such as ensuring prescription pads were carried in a locked carrying case and not left on view in a vehicle. However, the GP and ANP did not record prescriptions serial number data, as suggested best practice, NHS Protect Security of prescription forms guidance, August 2013. The practice manager and medicine lead showed us evidence the prescription pad box numbers were recorded when the boxes arrived in the practice and assured us that this would be implemented immediately and would devise a policy to ensure that all staff were aware.

The practice regularly checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. There was a clear cold chain protocol in place that followed NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.

We discussed with the ANP access to emergency medicines should they need them whilst they were on home visits. We were assured this was currently being reviewed and all staff carrying out home visits would have a secure container containing emergency medicines available to them at reception before they left the practice. This would be restocked and date checked once returned to the practice medicine manager.

Cleanliness and infection control

Infection Prevention and Control (IPC) was monitored within the practice and the IPC policy was available to all staff. This gave full information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids There was an identified IPC lead who ensured all aspects of the policy were implemented fully. The lead had attended appropriate training to carry out her role.

Infection control training was provided for all staff as part of their induction, and we saw evidence that the training was updated annually. The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated to them by the infection control lead.

Occupational health checks at pre-employment medical and Hepatitis B immunisation checks and updates were carried out every five years. The practice was informed of the results and a copy was kept on staff personnel files.

We observed the premises to be clean and tidy and saw that facilities such as hand gels, paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in all the patient toilets. We saw there were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Protective equipment such as gloves, aprons and masks were readily available. Curtains around examination couches were reusable and had a planned change date displayed on them. Examination couches were washable and were all in good condition. Each clinical room had a sharps disposal bin secured to the wall. There was a record of when each bin started to be used.

Cleaners were employed by the building management company and based in another part of the building. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. There was also a record that each task had been carried out. The practice

was cleaned in line with infection control guidelines, with the cleaners routinely attending every morning and evening. The staff we spoke with told us that if there were any spillages during the day they telephoned the cleaners who responded very quickly.

The IPC audit carried out by the practice lead had identified areas for improvement and these had been actioned. An example was to implement daily recording of cleaning of each clinical room cleaning and stock maintenance.

Legionella testing was part of the routine annual service carried out by the building management team.

Equipment

There was a contract in place between the practice and the building management company. The building management company had the responsibility for some equipment checks, such as fire extinguishers. Evidence was kept at the practice to confirm annual safety checks, such as for fire extinguishers, portable electrical appliances and equipment calibration, had been carried out.

Portable appliance testing had been carried out on all equipment.

Vaccines were kept in a locked fridge. The fridge temperature was monitored twice daily. Staff were aware of the action to take if the temperature was not within the acceptable range.

The computers in the reception and clinical rooms had a panic button system where staff could call for assistance if required.

Staffing and recruitment

The practice recruitment policy was up to date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service.

All the GPs had disclosure and barring service (DBS) checks undertaken annually by the NHS England as part of their appraisal and revalidation process. The nurses also had DBS checks undertaken and copies of the numbers were kept in the staff files.

The staff at the practice had all been employed for several years and there was little or no staff turnover. The staff were also multi skilled which enabled them to cover each other in the event of planned and unplanned absence.

The practice routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice.

Staff within the team had been supported through training to allow them to apply for other roles within the practice. We found the practice manager had completed training and has progressed from a reception role at the practice through to a clinical role and now to a management role.

The practice GPs was currently single handed and as part of the planned practice merger GPs from the merger practice were working within this practice. This meant there had been no requirement to employ a locum GP from any agency.

At present Dr Ahmed's practice did not have access to a female GP for patients should they request this, the GP and practice nurse informed us this had not been as issue but within the merger plans were plans to employ a female GP to address this. In the meantime the practice they had plans to merge with had a female GP for a limited time and Dr Ahmed's practice would attempt to secure an appointment with this GP if requested.

Monitoring safety and responding to risk

The Practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. The building management company were responsible for aspects of environmental safety. There was a system in place to inform the building management company of any concerns they had.

The practice ensured the appropriate checks and risk assessments had been carried out. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable.

The practice management team had procedures in place to manage expected absences, such as annual leave, and unexpected absences, for example staff sickness. Annual leave for staff was managed to ensure there were sufficient reception and clinical staff on duty each day

There was an incident and accident book and staff knew where this was located. Staff reported that they would

always speak to the practice manager if an accident occurred. They knew where to record the information and confirmed this was shared with other staff to reduce the risk of it happening again. All events and incidents were discussed at staff meetings.

We spoke with the chairperson of the Patient Participation Group (PPG). They told us the GPs and management team shared the lessons they had learned around actions that could be taken to improve the service. They said the practice management team were responsive to any concerns they had, and they were encouraged to share any ideas or any areas they felt the practice could be developed. We saw that staff refresher training was monitored to ensure staff had the right skills to carry out their duties. There were checks in place to ensure vaccines and other consumables were in date and ready for use.

An automatic external defibrillator (AED) was available in the practice. The practice carried out regular checks on the AED, so they could be satisfied it was available and ready for use. Staff had received training in cardiopulmonary resuscitation (CPR) and use of the AED. Oxygen was available within the building for use with the AED.

Arrangements to deal with emergencies and major incidents

We saw evidence that all staff had received training in Basic Life Support. This was updated on a regular basis. There was an AED in the practice. All staff knew where this was kept and how it should be used.

Comprehensive plans to deal with any emergencies that occurred which could disrupt the safe and smooth running of the practice were in place. We saw the business continuity plan that had been reviewed in October 2014. This covered business continuity such as adverse weather, loss of building use, loss of communications and responses to major incidents. All staff had access to the plan. Key contact names and telephone numbers were recorded in the plan.

The staff we spoke with were aware of the action to take in an emergency and how they could access additional advice. They told us that they were made aware of any changes in emergency procedures during staff meetings. Staff told us they had close working relationships with other professionals for support in emergency situations including staff from neighbouring practices within the building.

During our inspection we witnessed two patients whose care required transfer to the local NHS A&E department. This was carried out in a calm and controlled manner; key staff were given individual roles for example ringing the ambulance service, to complete with one person taking charge of monitoring the situation. On arrival of the paramedics care was clearly and quickly handed over to them to allow them to support the patient in their ongoing care. Paramedics told us they always received in-depth handovers from the staff and all calls made were appropriate to their service.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patients were appropriately referred to secondary and community care services. Referrals were discussed during clinical meetings. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. 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.

Read coding was used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. These codes improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions. Recent audits of read codes had allowed staff to ensure up to date data was available on their electronic system.

Practice nurses managed clinical areas such as diabetes, COPD and asthma. During regular assessments patients over the age of 55 years were asked if they had any memory problems this was fully recorded on a checklist to assist the nurse in ascertaining if the patient needed further referral. The practice had following a recent complaint built a robust relationship with the 'memory clinic team' at the local trust to assist them to support patients who may need to be tested further following showing signs of dementia.

Reception staff had a good understanding of their patient groups and would book longer appointments for patients with, for example, a learning disability or communication disability, so staff had the time to communicate effectively with the patient.

People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, eye disease, blood pressure and general wellbeing had been combined into single appointments to reduce the times patients needed to travel to the practice..

The practice nurses told us the practice used mindful watching for their patients who had specific needs and within this they recalled patients on a regular basis or as required if the patient/ carer/ family alerted them to any changes to reassess their needs and change care plans. Multi-disciplinary meetings were held regularly to discuss individual cases making sure that all treatment options were covered.

The GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical and practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs we interviewed were aware of their professional responsibilities to maintain their knowledge.

Care plans had been put in place for patients who met the criteria to avoid unplanned admissions to hospital. This was part of local enhanced services and the GP and ANP had initiated the plans with patients in their own home and included their family and/or carers where appropriate. Multi-disciplinary meetings were held regularly to discuss individual cases making sure that all treatment options were covered

Patients we spoke with said they received care appropriate to their needs. They told us they were included as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and other regular health checks and screening were on-going in line with national expectations.

Management, monitoring and improving outcomes for people

Patient's comments demonstrated that they were extremely satisfied with the care and treatment received from the doctors and nurse at the practice. Staff said they could openly raise and share concerns about clinical performance.

Staff told us medicine and safety alerts were shared with them and any actions required were discussed as a team and implemented and recorded fully in a short timescale.

The practice had a system in place for completing clinical audit cycles. Some of the audits were linked to medicine management information and safety alerts. Medicine reviews were carried out for patients where it was felt a change in prescribing guidelines would affect their medication. Records were kept of the decision making process, and where changes to medicines were not appropriate the reasons were recorded. Recent audits that

Are services effective?

(for example, treatment is effective)

had been completed included incorrect female coding which identified 16 patients with the wrong code, when re audited two months later it was found all codes were correct. Another audit of patients who were prescribed Domperidone highlighted eight patients who needed their medication reviewed in light of a Medicine and Healthcare Products Regulated Agency (MHRA) alert, further audit has since found there are no patients at the practice currently prescribed this drug. The local CCG also carried out regular medication audits at the practice.

The GP and ANP undertook joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. Clinical audits were undertaken on their results and the audits were used as a learning tool.

The practice monitored the number of patients who attended for regular reviews of their long term conditions.

The practice reviewed patients under a locally enhanced service to minimise admissions to hospital.

Regular clinical meetings took place with multi-disciplinary attendance across the practices due to merge to share information and provide reflection and learning to the benefit of the patients.

All staff maintained a range of mandatory training, including fire safety and safeguarding for adults and children. Some training was available to staff via e-learning, others were in conjunction with the other partner services.

Effective staffing

All the patients we spoke with were complimentary about the staff. We observed staff who appeared competent, comfortable and knowledgeable about the role they undertook.

We saw all new staff were provided with an induction pack and a formal induction to the practice. When a new member started work the length of the induction period was discussed with them, this period was flexible according to the person previous experience.

Systems were in place to ensure all nurses were registered with the Nursing and Midwifery Council (NMC) and GPs with the General Medical Council (GMC). Doctors were revalidated.

The practice employed an advanced nurse practitioners (ANP). The ANP was able to have more responsibility than practice nurses and see a broader range of patients. The management team told us they had received positive feedback about the availability of the ANP from GPs, nurses and patients, and they were an integral part of the clinical team.

All staff had an annual appraisal. During these meetings a personal development plan was put in place and training needs were identified.

Staff were fully informed about the pending merger and told us they were consulted at all stages and their opinion asked for.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with the neighbouring practice with whom they were planning a merger. They also had close working relationships with the community services who shared the building and professionals from other disciplines to ensure all round care for patients. Information about risks and significant events was shared openly and honestly at practice meetings.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood test results, letters from the local hospital including discharge summaries and out of hours provider communication could be received electronically

Minutes of meetings evidenced that district and palliative nurses attended the practice MDT meetings to discuss the palliative patients registered with the practice. The detail evidenced good information sharing and integrated care for those patients at the end of their lives.

The practice had good relationships with the management team of the local homeless hostel and as such provided registration for all people living at the hostel with the practice. This often continued once they moved to a more permanent home unless they moved out of the area. Patients residing at a local mental health rehabilitation centre accessed services at the practice and staff at the practice worked closely with the staff to ensure the care needs of the patients were fully met. This included regular appointments attended by the patient and carers.

Are services effective?

(for example, treatment is effective)

The practice nurse had strong links with the local women's aid and wish centre. This centre assisted patients who were in situations where they required a safe house or advice to deal with leaving an abusive partner. The nursing team referred patients from the practice to them as required.

The practice nurse discussed with us two recent situations where they had had to work with local police, health visitors and social workers to address a situation that was picked up in the practice to ensure the safety of another patient at the practice. These had both reached a positive, protective and safe outcome for the patients. We also saw recent examples whereby a person in vulnerable circumstances had been identified and saw how staff had intervened to provide help, arranged appointments and liaised with the police and other health and social care professionals to assist the patient.

Staff understood about safeguarding vulnerable patients, they had access to the practice policy and procedures and they were appropriately trained.

Information sharing

There was a practice website with information for patients including signposting, services available and latest news up to date information on the proposed merger was available to all patients both via the website and within the practice waiting area. The chairperson of the patient participation group told us this information was updated as required.

The GP met regularly with the practice nurses and administration staff. Information about risks and significant events was shared openly and honestly at cross practice meetings. The GP attended CCG meetings and shared this information, this kept all staff up to date with current information around local enhanced services, requirements in the community and local families or children at risk.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner.

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for people who attended the practice. The GPs and the nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation. Nursing staff at the practice had started to complete annual Mental Capacity Act and Deprivation of Liberty training updates.

The GP was currently awaiting a date for Mental Capacity Act training; however we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

The practice policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing.

The nurses told us they used pictorial evidence to ensure people understood their treatment before carrying out their treatments. This was especially effective in patients with learning disabilities. Staff were aware of how to access advocacy services.

Language line was available within the practice however we did not see any information in the waiting room to demonstrate this, the practice manager rectified this before we left the practice.

The consent policy was available and had been updated.

Health promotion and prevention

All new patients were offered a consultation and health check with one of the practice nurses. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle.

One nurse we spoke with advised that patients who had not visited the practice for some time had been identified via the reception staff and appointments offered to them.

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Any housebound patients with long term conditions and those with a diagnosis of dementia were routinely visited each year at home so they could be given information and advice that may prevent them being unnecessarily admitted to hospital. We saw one of the practice's business objectives was to increase home visits to this group of patients and this had now been achieved.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with told us they felt well cared for and that staff were very considerate, friendly and genuinely concerned and attentive to their needs. Privacy during consultations was maintained; curtains were used to hide modesty and windows were obscured even though the practice was on the first floor. Conversations could not be heard through closed doors. Patients spoke highly of the practice, the reception staff and the doctors. One patient went out of their way to tell us about the wonderful care they had received at the practice that day and every time they visited.

Patient feedback was very complimentary about the reception staff and their attention to detail and willingness to try to help. Reception staff were respectful and patient. There was a genuine and friendly connection between the reception staff and patients of all ages.

We received 33 patient comment cards and all were very positive about the service they received. Patient experience feedback showed a high degree of satisfaction with the service provided and the attitude towards them by the staff who delivered it. Patients described the practice as my friendly family doctor and indeed most of those we spoke with told us that all their families, children and grandchildren, used the same practice.

Care planning and involvement in decisions about care and treatment

Patients were encouraged and supported where possible to take responsibility for their conditions and to be involved in decisions about medication and other forms of treatment.

Patients we spoke with told us they were always asked for their consent before any procedure or treatment was undertaken. We were told that a chaperone always 'appeared' even though some patients told us they did not feel this was necessary, but they realised the reason they were there was to offer support. We were also told there was ample opportunity to discuss any health concerns many patient's told us they "never felt rushed" during consultations. Patients told us they were fully aware of their treatment plans and the GP or nurse was excellent at checking they understood before they left the surgery.

All the staff we spoke to knew how to access and use Language Line if required. Language Line is a worldwide telephone interpretation service. Literature was available in different languages if and when required.

We saw that patients' information was treated with the utmost confidentiality and that information was shared appropriately when necessary using the correct data sharing methods.

Patients with learning disabilities had their care plans updated annually or as required by the practice nurse in conjunction with the local LD specialist and the family and/or carer of the person.

Patient/carer support to cope emotionally with care and treatment

Staff were able to give us examples of where they had gone over and above what was expected of them to support patients emotionally. This included supporting a parent whose child and husband had both been admitted as emergencies to the local NHS Trust on the same day.

Notices and leaflets in the patient waiting room signposted patients to a number of support groups and organisations. Patients were able to self-refer to these when they had been brought to their attention. In addition, we saw evidence that patients were referred to counselling services, including bereavement counselling, when this was appropriate.

As patients were well known to the reception staff any carer responsibilities were already known to them. However the practice routinely asked patients if they had caring responsibilities. They told us they were offered additional support where appropriate or requested.

We saw evidence where comments or observations by reception staff had led to patients receiving care that they may not otherwise have received but for the diligence of all these staff. We were told about incidents where patients had been protected from harm thanks to the reception staff awareness.

We looked at 33 CQC comments cards that had been completed and spoke to 8 patients. All comments were positive. Comments stated that they were pleased with the service, were treated with respect and said that the GP and all staff went above and beyond what was required to make sure the care offered was appropriate. Patients we spoke to said they always had enough time to discuss their

Good

Are services caring?

problems and could make longer appointments if they needed them. All patients we spoke with said they would not hesitate to recommend the practice to friends and all their family were already registered at the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was pro-active in providing support to patients who attended the practice and carried out home visits to support patients who were unable to attend. Patients who were housebound or resident in care homes were identified and visited at home by the advanced nurse practitioner to receive their influenza vaccinations.

The staff knew all the practice patients well and were able to identify a person in crisis. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies both in and out of hours.

The practice held a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities (LD). The practice offered longer appointments for people with learning disabilities and carried out joint reviews with the patients, their families, carers and Community LD specialist team on a quarterly basis to address, adapt and monitor the care plans in place for this group of patients.

The practice supported the healthcare needs of a local mental health rehabilitation centre and these patients residing in this service had access to the practice by mobile phone at any time during opening hours. This phone was placed at reception but during lunchtime or busy periods the phone could be carried around by staff to ensure timely answering and addressing of the needs of this group of patients.

Staff had extensive links with local organisations to assist them in providing effective and timely support as required for people finding themselves in vulnerable situations. All the practice staff pro-actively followed up and shared information received about vulnerable patients.

The support agencies allowed the nurse to recommend patients to them, but the person themselves had to actually ring for the appointment this ensured they were fully aware of their referral and the service they could access. A number of examples were discussed with the team where clinical and reception staff had used their initiative when they had escalated a concern or passed on information which had led to a positive outcome for the patient. Information available at the time had been as little as a comment about a patient in the waiting room, or an observation that raised concern about a patient who did not appear 'as normal'. One situation had led to police, social workers and health visitors being involved to place a vulnerable person in a place of safety.

Patients who chose to disclose sensitive information to the nurse were supported to receive appropriate care and support from other professional organisations. We were told of a recent incident where a patient with LD had disclosed sensitive information to the nurse and this had been escalated as appropriate and actions taken to support and protect the individual.

Homeless patients residing in the local hostel were welcomed into the practice they were encouraged to attend for routine health care monitoring. The manager of the hostel who was also a patient rang the practice to make appointments on their behalf where necessary. If a patient failed to attend the reception staff would alert the manager of the hostel if he had made the appointment.

Working together with the multi-agency organisations in the area the staff at the practice ensured their patients were fully supported with up to date information to assist them to remain safe and cared for. Therefor having a positive impact on the patients' health and wellbeing.

The patients we spoke with told us that there was rarely a problem with appointments and they were able to get in to see GP when needed. One patient told us that most of the time they saw the GP on the same day they requested the appointment but they were retired so could come at short notice. They told us that if this was not possible it was explained to them and they rarely waited more than 24hours.

One parent told us they had rung that morning for an appointment for their child and was asked to come as soon as was practical for her and she would be seen. The child was seen and was referred by ambulance to the local NHS Trust. The mother told us she was very happy with the service provided and the prompt attention to her child's needs. The nurse rang the mother later during the inspection to check up on the child's progress.

The practice did not currently have access to a female GP but patients we spoke with told us this was not an issue as they had been with the GP for many years and were comfortable with him. They told us they always had a

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

chaperone even when they didn't request one so were happy with this service. The GP told us the plan once the merger was complete was that patient's would be able to access a full time GP within the new practice.

Both patients and staff told us they were fully aware of the progress of the planned merger and all changes were fully discussed before being implemented. They all told us they felt integral to all aspects of the practice.

We spoke with the chairperson of the Patient Participation Group (PPG). They gave us examples of improvements that had been made following discussions between the PPG and the practice. Changes to the telephone answering system suggested by the PPG were now being evaluated to make positive changes in the practice.

Tackling inequity and promoting equality.

The premises were shared with other GP s and community services. The waiting area for this GP was clearly signposted. One patient told us there had been instances where patients had waited in the wrong place and missed the screen which announced their appointment, but in those cases the GPs had come to waiting area to retrieve the patient.

The seats in the waiting area were able to be cleaned and all of one height and size, some had arms on to assist people to rise easily.

Audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available.

Staff reported that there was little diversity within their patient population. However they were knowledgeable about language issues and were aware of how to access an interpreter to the benefit of the patient. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

Access at the entrance of the surgery was good with automatic doors to the entrance. As the practice was based on the first floor there was access via a lift or stairs dependant on patient's needs.

There was a good appointment system where people could receive same day emergency appointments, telephone consultations with the GP or ANP whenever possible, call backs, and home visits by the doctors. The nurses and ANP also went on home visits, subject to availability.

Appointments were available Monday to Friday 8.30am to 6.30pm and an extended clinic on Monday from 6.30pm to 9pm. With telephone appointments for emergencies between 12.30pm and 2pm daily.

The practice used the services of the out of hours (OOH) provider to carry out an Acute Visiting Service for patients who required home visits as a matter of urgency and could not wait until after surgery finished. These visits were carried out by GPs from the OOHs service and details of treatments and actions taken were sent to the GP practice as soon as possible. The reception staff tried to ring these patients and check they had been visited by the OOH service and did not require any further support.

We saw that the practice did respond to feedback where they were able.

There was adequate car parking available on the premises and in the street.

A Patient Participation Group was well established across both practices that were to merge, they had recently advertised for younger members but had not been successful so far.

The practice had a very informative practice leaflet outlining the staff, opening times and the expectations of the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice All complaints were discussed at the cross practice governance meetings and shared with staff as appropriate.

We saw the summary of complaints that had been received since April 2014. Prior to the new practice manager starting in April 2014 no comprehensive record had been kept. A summary of the complaint, details of the investigation, the person responsible for the investigation and whether or not

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

the complaint was upheld was recorded. How the practice had been made aware of the complaint was also recorded, and we saw that any verbal indications of dissatisfaction were investigated.

We looked at the four complaints received that had been investigated by the practice. We saw that these had all been thoroughly investigated and the patient had been communicated with throughout the process. The practice was open about anything they could have done better, and there was a system in place so learning as a result of complaints received was disseminated to staff. We were told by the GP he had discussed any complaints concerning his practice at his appraisal and further learning or training which had been identified had been carried out.

Patients' comments made on the NHS Choices website were monitored. These were discussed at practice meetings and where changes could be made to improve the service these were put in place.

All the staff we spoke with were aware of the system in place to deal with complaints. They told us feedback was welcomed by the practice and seen as a way to improve the service. There was a notice in the reception area informing patients how to make a complaint.

The patients we spoke with told us they would be comfortable making a complaint if required. They said they were confident a complaint would be fairly dealt with and changes to practice would be made if this was appropriate.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We saw the business plan that was in place, and saw the practice's vision and values were included in various documents including the practice leaflet. The practice was currently undergoing a merger with a neighbouring practice and this was fully documented in the business plan.

We spoke with eight members of staff. They were all aware of the vision and values of the practice and knew what their responsibilities were in relation to these. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Staff told us they were updated on a weekly basis where needed on the progress of the merger. Patients were updated via information in the waiting room or the PPG.

Governance arrangements

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. These systems were run in conjunction with the merging practice to ensure a smooth transition once the merger was complete.

All staff were included in areas of responsibility such as monitoring appointments and introducing systems to improve the smooth running of the practice.

All staff we spoke with were aware of each other's responsibilities and who to approach to feedback or request information. Those systems and feedback from staff showed us that strong governance structures were in place.

The practice manager took an active role for overseeing the systems in place to ensure they were consistent and effective. The practice manager was also responsible for ensuring that policies and procedures were kept up to date and that staff received training appropriate to their role. There was evidence that feedback from patients was discussed with all staff and learning was applied.

Leadership, openness and transparency

All staff we spoke with told us they supported the merger of the two practices and felt this was a positive move for both practices to enhance patient care.

All staff were observed to follow the vision and values of the practice which were very clear. There was an open and honest culture and clinical, administrative and reception staff all encompassed the concepts of compassion, dignity, respect and equality. They welcomed input from patients of the practice and acted upon feedback. We observed a friendly relationship with the reception staff and patients, patients spoke very fondly of the reception team.

Staff understood their roles and were clear about the boundaries of their abilities.

Staff felt supported in their roles and were able to speak with the new practice manager at any given time. Staff felt valued and were rewarded for the good work they provided.

The practice manager undertook appraisals for the reception, administration and nursing staff on an annual basis. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. The GP carried out the appraisal for the advanced nurse practitioner and a date was currently in the diary for this process. The practice manager had had her appraisal carried out by the GP.

The GP received appraisal through the revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

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

The practice staff and patients had an excellent communication process they were open and honest and each group told us they felt the others valued them.

Patients we spoke with reported that they felt comfortable providing concerns, compliments or complaints to all members of staff and in particular to the practice manager. Information received was acted upon and we saw evidence that changes were made to working practice where ever possible.

A Patient Participation Group was well established across both practices and was fully involved in all aspects of the practice from complaints to the merger process. The chairperson told us he felt they were an 'integral part of the

Are services well-led?

Good

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

team' as they were listened to and their comments acted upon where possible. They felt well informed and comfortable with everything that was happening at the practice at the present time.

Management lead through learning and improvement

We saw a clear understanding and commitment to the needs of staff and ensuring they had access to learning and improvement opportunities.

Newly employed staff had a period of documented induction. Learning objectives for existing staff were discussed during appraisal and mandatory training was role relevant. E-Learning was carried out for some training with face to face for other training.

Nurses and GPs kept their continuing personal development up to date and attended other courses pertinent to their roles and responsibilities within the practice such as domestic violence and infection control. This ensured that patients received treatment which was most current.

The GP told us he had discussed some recent issues at his appraisal and had identified further learning for his development.

The staff files we reviewed provided evidence that training was up to date and staff had attended appraisal meetings with their line manager. We also saw that new staff followed a formal induction programme where they received regular feedback and were in turn asked for their opinion of how their induction programme was being managed.

Formal appraisals were evident and nursing staff told us they had clinical supervision on a weekly basis but this was informal. This was carried out with the practice nurses from the merging practice to ensure they could share good practice across both sites. They nurses may wish to consider recording dates of supervision for future reference. The staff we spoke with told us they regularly attended training courses. Mandatory training was arranged for them and they were able to request relevant training courses that would enhance their performance at work. Clinical staff told us they were supported to maintain their continual professional development (CPD).

Staff meeting took place on a monthly basis. The practice staff were focussed on how they could merge in a seamless manner and improve the service they provided to patients under their care.

The practice had completed reviews of significant events and other incidents and shared these with staff via their regular meetings to ensure the practice improved the outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.