Dr Singh`s Surgery

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?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Singh's Surgery, also known as Clifford Road Surgery, on 16 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services to the six population groups we inspect - People whose circumstances may make them vulnerable; Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); and People experiencing poor mental health (including dementia).

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Most risks to patients were assessed and well managed, with the exception of fire safety.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified, although not all staff had received training in safeguarding vulnerable adults.
- There was a good skill mix amongst the GPs with some clinicians having specialised areas of expertise.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they could make an appointment when they needed one, although some found it difficult to access the practice by telephone in the mornings. Urgent appointments were available the same day but may not be with a GP of the patient's choice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

Summary of findings

- The practice sought feedback from patients, staff and the patient participation group (PPG), which it acted on.

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

Importantly, the provider should:

- Ensure all staff receive training in the safeguarding of vulnerable adults.
- Carry out a comprehensive risk assessment to identify, assess and mitigate the risks associated with fire.
- Ensure reference checks for all staff are consistent with the practice's recruitment policy.
- Ensure staff are familiar with the practice's vision and values.
- Ensure information on whistleblowing is available to staff should they have any concerns.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. All staff had received relevant role specific training in child protection and knew how to recognise signs of abuse in vulnerable adults and children, although not all staff had received training specifically in safeguarding vulnerable adults. Most risks to patients who used services were assessed and well managed, such as those relating to infection control, medicines management, and business continuity. A health and safety check had been carried out which included checking fire safety equipment, however the check was not comprehensive and did not identify, assess and mitigate the risks associated with fire. Portable equipment had been calibrated and tested for safety. There were enough staff to keep patients safe. Recruitment protocols were being followed, but the evidence for obtaining references was inconsistent as some staff had one reference despite the practice policy stating two were required. Staff who performed chaperone duties had received training and understood their responsibilities when acting as chaperones.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality and nationally. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. We reviewed referrals made by the practice and found many of these were completed with minimal clinical information, therefore we raised this issue with the provider who agreed to speak with clinical staff and review all future referrals in more detail. Staff had received training appropriate to their roles and any further training needs had been identified. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and regular meetings were held. There was evidence of completed clinical audits to improve patient outcomes, and this information was shared with staff during practice meetings.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the national patient survey 2015 showed that respondents rated the practice below the CCG and national averages for consultations with the GPs, and similar to the CCG and national averages for consultations with the nurses. Results from the practice survey 2013 showed that 77% of patients said the doctors at the surgery were good, and this figure increased to 80% in 2014. Results from the Friends and Family Test December 2014 to March 2015 indicated that the majority of patients who responded were satisfied and would recommend the service. Patients we spoke to and the comment cards we received said patients were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had a significant number of patients who could not speak English as a second language, and some staff spoke languages other than English to aid communication with these patients.

The majority of patients we spoke with were satisfied with the appointments system, although some commented that telephone access in the mornings could be improved. Patients confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be with the GP of their choice.

The practice had sought feedback from staff, patients, and the patient participation group, and had acted upon that feedback. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The GP partners were able to describe the practice's vision and a strategy, but not all staff were aware of this. There was a clear leadership structure and designated staff led in specific areas such as safeguarding, infection control and complaints. Staff felt management were approachable and supportive. The practice had a number of policies and

Summary of findings

procedures to govern activity, although there was no whistleblowing policy to support staff if they had concerns. Governance issues were discussed daily between the GP partners, or more formally during the quarterly practice meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews 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. The practice had a lower percentage of patients over the age of 75 (1.6%) when compared to the national average (7.6%). The income deprivation level affecting older people was 34 compared to the national average of 22.5.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia care. All patients over the age of 75 had named GP. The practice was responsive to the needs of older people, and offered home visits for those with enhanced needs. Clinical staff worked with a multidisciplinary team to discuss care planning for patients who required extra support. They also signposted patients who required further advice and care to support groups and organisations.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The percentage of patients at the practice with a long standing health condition (46.5%) was lower than the national average (54%). The percentage of patients with health related problems in daily life (50.2%) was higher when compared to the national average (48.8%).

Nursing staff assisted the GPs in chronic disease management. Patients with long term conditions were invited to a structured annual review to check that their health and medication needs were being met. Nationally reported data showed that outcomes for patients were good for chronic conditions such as chronic obstructive pulmonary disease (COPD), diabetes, and asthma, and staff followed National Institute for Health and Care Excellence (NICE) guidance around treatment for these groups of patients.

For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Longer appointments and home visits were available when needed.

Families, children and young people

Good

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

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The practice had less children registered when compared with the national average. For example, children aged zero to four represented 5.5% (national average 6.0%); children aged five to 14 represented 7.2% (national average 11.4%); and those aged under 18 years represented 9.2% (national average 14.8%). The income deprivation level affecting children was 32 compared to the national average of 22.5.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, health visitors were attached to the practice and discussed children at risk. There was a designated GP who led on child protection, and all staff were aware of their responsibilities for safeguarding children.

Antenatal and postnatal care was offered as part of a shared care programme with the hospital, and the practice nurses provided childhood immunisations. Performance for all standard childhood immunisations was similar to the local averages. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice also offered a family planning service, including intrauterine contraceptive device (IUCD) fitting and subfertility referrals for patients trying to conceive. Advice on sexual health was provided, and chlamydia screening was routinely offered to patients aged 16-25 years during the new patient check-up.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice had a predominantly young adult population between the ages of 20 and 39. The number of patients in paid work or full-time education was higher than the national average, 77.7% compared to 60.2%.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments from 18:30 to 19:30 were available on Monday, Tuesday, Thursday and Friday evenings.

The practice offered online facilities to book appointments and request repeat prescriptions. Telephone consultations were available for patients who found it difficult to access the practice. Text message alerts were used to confirm and remind patients of their appointment. There was a range of health screening programmes (including cervical and bowel cancer screening), and

Summary of findings

NHS health checks (for patients aged 40-75) that reflected the needs for this age group. Health promotion advice was offered and health promotion material was available at the practice and on the website.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including housebound patients, carers, those with a learning disability, and patients receiving palliative care. An annual check-up and longer appointments were offered to patients with a learning disability. The practice was commissioned for the unplanned admissions enhanced service and we were told that care plans were completed for 2% of their most vulnerable patients, in line with the requirements for the enhanced service.

The percentage of patients with a caring responsibility was lower than the national average at 14.1% compared to 18.2%. The practice's computer system alerted GPs if a patient was a carer, and carers were offered health checks, the flu vaccination, and referred to various support services.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice also provided longer appointment times for patients who required emotional support and signposting to external organisations. For example, victims of domestic violence, and asylum seekers.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Annual physical checks and mental health reviews were offered to patients on the mental health register. Data from the quality and outcomes framework (QOF) indicated that a comprehensive care plan was in place for 100% of patients with schizophrenia, bipolar affective disorder and other psychoses.

The practice carried out dementia reviews and two GPs and two nurses had received additional training on how to care for people with mental health needs and dementia. The practice regularly worked with multi-disciplinary teams in the case management of

Summary of findings

people experiencing poor mental health. Patients were offered referral to emotional support services such as counselling, community mental health services, and a drug and alcohol addiction service.

Summary of findings

What people who use the service say

We also spoke with four patients on the day of our inspection, and one member of the Patient Participation Group (PPG) following our inspection. The majority of patients were positive about the practice and their experience of the services provided. Patients said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment. They told us they were happy with the cleanliness of the environment and the facilities available. They said they could get an appointment when they needed one, although some commented that it was difficult getting through to the service on the telephone in the mornings. We received 34 CQC comment cards for this practice. All comments were positive about the practice and staff.

Data from the national Patient Survey 2015 indicated that 66% of respondents described their overall experience of the practice as good, compared to the clinical commissioning group (CCG) average of 79% and national average of 85%. Respondents rated the practice below the CCG and national averages for consultations with the GPs, and similar to the CCG and national averages for consultations with the nurses. Eighty-nine per cent of respondents were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.

Results from the practice survey carried out in March 2013 showed that 77% of patients said the doctors at the surgery were good, and in January 2014 this figure increased to 80%. Results from the Friends and Family Test December 2014 to March 2015 indicated that the majority of patients who responded were satisfied and would recommend the service.

Areas for improvement

Action the service SHOULD take to improve

• Ensure all staff receive training in the safeguarding of vulnerable adults.

• Carry out a comprehensive risk assessment to identify, assess and mitigate the risks associated with fire.

• Ensure reference checks for all staff are consistent with the practice's recruitment policy.

• Ensure staff are familiar with the practice's vision and values.

• Ensure information on whistleblowing is available to staff should they have any concerns.

Dr Singh`s Surgery

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 specialist advisor. The specialist advisor was granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Dr Singh`s Surgery

Dr Singh's Surgery, also known as Clifford Road Surgery, provides GP led primary care services through a General Medical Services (GMS) contract to around 8,900 patients. (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS Hounslow Clinical Commissioning Group (CCG). The practice registers patients living in the surrounding areas of Hounslow, Heston, Cranford, Southall, Norwood Green, Isleworth, Osterley, Bretford, Chiswick, Whitton, Hayes, Feltham, Staines, Bedfont, Teddington, Hanworth, Hampton, Kingston.

The practice staff comprise of two GP partners (one male and one female); a male salaried GP; two locum GPs (one male and one female); three practice nurses (two of whom are locums); three phlebotomists (two of whom are locums); a practice manager; an enhanced services manager; and a small team of receptionists and administrative staff. The number of sessions covered by the GPs equates to 3.5 whole time equivalent (WTE) staff. The number of sessions covered by the nurses from 1st April to 31st August equates to 1 WTE staff, and 1st September to 31st March equates to 1.5 WTE. The phlebotomists cover 12 hours between them. There are also district nurses and health visitors attached to the practice.

The practice is located in a converted residential property with five consulting rooms on the ground floor.

The practice is open every weekday from 08:30 to 18:30, except Wednesday afternoons when it is closes at 13:30. Patients who call the practice from 08:00 to 08:30 are directed to an out-of-hours GP service. Appointments are available Monday to Friday from 9:00 to 13:00, and 16:00 to 18:30 (except Wednesday). Late appointments are offered on Monday, Tuesday, Thursday and Friday from 18:30 to 19:30. Appointments must be booked in advance over the telephone, online or in person. The practice opted out of providing out-of-hours services to their patients. On Wednesday afternoons and outside of normal opening hours patients are directed to an out-of-hours GP, or the NHS 111 service.

The practice has a predominantly young adult population between the ages of 20 and 39. There is a lower percentage (than the national average) of patients aged under 18 years (9.2% compared with 14.8%), and of patients aged 75 years and over (1.6% compared with 7.6%). There is a lower percentage (than the national average) of people with a long standing health condition (46.5% compared to 54%), but a higher percentage (than the national average) of people with health related problems in daily life (50.2% compared to 48.8%). The average male and female life expectancy for the CCG area is similar to that of the national average.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures; treatment of disease, disorder and injury; family planning; and maternity and midwifery services. The provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

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

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

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

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

Before visiting we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 16 June 2015. During our inspection we spoke with a range of staff including: two GP partners; one locum GP; one practice nurse; the practice manager; and an administrator. We observed how people were being cared for and talked with carers and/or family members. We sought the views of four patients, and spoke to a member of the patient participation group. We reviewed the personal care or treatment records of patients. We reviewed 34 comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an incident involving a member of staff not alerting the practice of their absence in time for adequate cover measures to be put in place. The practice managed to get cover later in the day. The incident had been reported to the relevant staff members and investigated internally. The incident was shared with other staff during a practice meeting, and an action plan developed to prevent future occurrences.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred within the last year and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used a 'significant event report template' on the shared drive and sent completed forms to a GP partner. We were shown the system used to manage and monitor incidents. We saw evidence of action taken as a result and that the learning had been shared. For example, a significant event was recorded when there was a power cut. The practice were able to adapt the service provided during the disruption. However they noted that they were unable to identify the fridge temperature to ensure vaccinations were stored at the correct temperatures as the internal fridge temperature was affected by the power cut. In response to the incident the practice purchased an additional fridge thermometer which would not be affected if there was a power failure. We saw evidence that the incident and learning points had been shared with staff at the next practice meeting. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

The practice had a policy for sharing and acting on guidance and safety alerts including those from the National Institute for Health and Care Excellence (NICE), the local clinical commissioning group, the Medicines and Healthcare products Regulatory Agency (MHRA), and the National Patient Safety Agency (NPSA). Safety alerts were received by a GP partner and disseminated by email to relevant staff. A GP we spoke with was able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training in child protection. For example, the GPs had received Level 3 child protection training, the nurses Level 2 or 3, the practice manager Level 2, and other non-clinical staff Level 1. There was evidence that two GPs and one nurse had undergone training in safeguarding vulnerable adults, however there were no records to show that other staff had received training. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

A GP partner had been appointed as the dedicated lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy which was visible in the waiting room and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Two reception staff told us they had acted as a chaperone when nursing staff were not available, and had received in-house training to perform these duties. They understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had recently applied for these staff to receive a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out daily which ensured medication was stored at the appropriate temperature.

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

Repeat prescriptions could be requested in person, online, via e-mail, post, or fax. Designated administrative staff could generate authorised repeat prescriptions. All prescriptions were reviewed and signed by a GP partner before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice received an annual prescribing visit via their clinical commissioning group (CCG) and we were shown the report from June 2014. We were told that the practice had taken action in response to prescribing data. For example, reviewing patterns of antibiotic prescribing, offering topical alternatives where possible, educating patients about antibiotic use, and providing advice on prescription labels.

The management of patients taking high risk medicines, such as methotrexate, was via a shared-care protocol with the hospital. The practice could access the hospitals records to review patients' blood test results, and appropriate action was taken based on the results. The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were up to date and evidence that they had received appropriate training to administer vaccinations.

Cleanliness and infection control

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

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

There were practice leads for infection control and they had undertaken further training to enable them to provide advice on the practice's infection control policy and carry

out staff training. We were told all staff had received in-house training about infection control specific to their role. Notices about hand hygiene techniques were displayed in clinical rooms, and hand washing sinks with soap, hand gel, and hand towel dispensers were also available.

The practice had received an infection prevention and control visit from North and East London Commissioning Support Unit in November 2014. The audit referred to areas that required improvement, including purchasing foot operated bins, replacing the sinks in certain clinical rooms, and replacing chairs with fabric covers in clinical areas with chairs that comply with infection control guidelines. The practice had addressed most of the areas which required immediate attention. The practice had also received an external risk assessment in January 2015 for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was tested and displayed stickers indicating the last testing date which was June 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, and blood pressure measuring devices had taken place in June 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at ten staff files and most contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, the evidence for obtaining references was inconsistent as three employees had one reference, despite the practice's policy stating 'two references from previous recent employment' were required. We were told it was now practice policy for non-clinical staff to have DBS checks, and we saw the practice had recently applied for all non-clinical staff to receive a DBS check.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including GPs, nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety and fire policy. Health and safety information was displayed for staff to see.

The practice kept paper and electronic patient records. Electronic records were password protected and could only be accessed by authorised staff. Patients' paper records were stored securely.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked on a monthly basis.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Good

Are services safe?

the practice. Risks identified included failure of telecommunications, power failure, and loss of access to the building. The plan also included a risk assessment of the services provided by the practice, and these were then prioritised based on their impact to the service. For example, monitoring of patients on high risk medicines and wound care management were classed as high priority services, and cervical screening and travel vaccines were assessed as lower priorities. The plan was reviewed in March 2015.

The practice had carried out a health and safety check in March 2015. This included reviewing the health and safety and fire policy; an inspection of equipment and electrical items; a review of first aid equipment; and an inspection of the fire extinguishers. The check was not comprehensive and did not identify, assess and mitigate the risks associated with fire. We were told that staff received health and safety training at induction, and records showed staff had received refresher training in health and safety in April and May 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners, including local referral pathways, was accessible to staff electronically. The GPs told us they attended educational meetings with their locality group and the clinical commissioning group (CCG), and NICE guidelines were reviewed here. Information was then disseminated to relevant staff during practice meetings or by email. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks with the GPs and nurses. The practice's performance was above the CCG and national averages for patients with diabetes who had a blood pressure reading in the preceding 12 months of 150/90 mmHg or less (practice 95.8%, CCG 90.5%, national 91.7%); patients with diabetes with a record of a foot examination and risk classification within the last 12 months (practice 97%, CCG 89.1%, national 88.3%); and patients with diabetes who had received the seasonal flu vaccination (practice 96.8%, CCG 93.4%, national 93.4%). Feedback from patients confirmed they were referred to other services or hospital when required.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GP partners met on a daily basis to discuss any issues. Clinical meetings were incorporated into the quarterly practice meeting and we saw from minutes that locum clinical staff were invited to these meetings. A locum GP told us that they could not usually attend the meetings, however a GP partner met with them after each clinical session to discuss any concerns, receive a handover, and discuss new local and national guidelines that were relevant.

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

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

The practice showed us five clinical audits that had been undertaken in the last four years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We reviewed an audit on outpatient referrals. The initial audit had been carried out in 2011, and a re-audit took place in 2012. The initial audit identified a high referral rate for the following specialities: cardiology; endocrinology; gastroenterology; gynaecology; neurology; and orthopaedics. Action was taken to review referrals made and utilise more community services where possible. The re-audit showed that the practice had the 7th lowest referral rate for the CCG area, however there were still specialist areas (such as gynaecology) with high referral rates. We were told this was due to the above average number of young women (aged 20 to 39) registered with the practice that needed antenatal and subfertility referrals. The information from the audit was shared with clinical staff, and discussed at a locality meeting with other practices.

Good

Are services effective?

(for example, treatment is effective)

The practice was registered with the CQC for family planning services. One of the GP partners carried out annual audits on intrauterine contraceptive device (IUCD) fitting, and we saw from the 2014 audit that there were no complications in 100% of the procedures undertaken at the practice.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice achieved 98.5% (887/900 point) of the total QOF target in 2014, which was above the CCG average of 93.2%, and the national average of 93.5%. This included achieving 99.3% (605.58 out of 610 points) for the clinical domain, where most performance indicators for conditions such as chronic obstructive pulmonary disease (COPD), dementia, depression, diabetes, and hypertension were better than the local and national averages. The practice told us that they had maintained their performance in QOF for 2015 by achieving 98.9% (553 out of 559 points) of the total target.

The practice received an annual prescribing visit via their clinical commissioning group (CCG). We were shown the most recent report (2014/15) which stated that the practice were within budget for the year 2013/14. The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing and this required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, such as patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions such as diabetes, COPD and asthma. QOF data showed that the practice were above the CCG and national averages for the percentage of patients with COPD who had received a review, including assessment of breathlessness in the preceding 12 months (practice 100%; CCG 92.4%; national 89.6%). The QOF data also showed that the practice were above the CCG and national averages for patients who had received an asthma review in the preceding 12 months (practice 85.5%; CCG 75.7%; national 75.5%).

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area, for example in antibiotic prescribing.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. There was a skill mix among the doctors with some having additional diplomas in family planning, obstetrics and gynaecology, and geriatric medicine. All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff, with the exception of locum staff, undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice provided mandatory training and support for continuing professional development. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, administering vaccines and carrying out cervical smears.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results,

Good

Are services effective?

(for example, treatment is effective)

and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically, by post or by fax. There was a practice policy for reviewing correspondence. Out-of-hours reports, 111 reports and urgent pathology results or letters were seen and actioned the same day they were received by one of the GP partners. The GP who saw these documents and results was responsible for the action required. All staff we spoke with were familiar with the practice's policy, understood their roles and felt the system in place worked well. They told us there were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 6.57% compared to the national average of 13.6%. Rates were also low when compared to local averages. For example, data from the CCG confirmed that the practice's non-elective admissions rate per 1,000 people for 2014/15 was 60.5, which was lower than the locality group average of 85.8 and the clinical commissioning group (CCG) average of 84.1. The practice was commissioned for the unplanned admissions enhanced service and we were told that care plans were completed for 2% of their most vulnerable patients, in line with the requirements for the enhanced service. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We reviewed the care plan for one of these patients and found it had been comprehensively completed. The practice had a process in place to follow-up vulnerable patients discharged from hospital, and we saw that the protocols for actioning hospital communications was working well in this respect. The practice also worked with the 'integrated community response service' to avoid unplanned hospital admissions for vulnerable patients, and to support those recently discharged from hospital.

The GP partners attended monthly multidisciplinary team meetings with other practices in their locality group to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, and people from vulnerable groups. These meetings were attended by social workers, district nurses, mental health practitioners, and hospital consultants, to discuss care planning for these patients.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs, such as those in receipt of palliative care, with the out-of-hours services. Electronic systems were also in place for making referrals via the 'Referral Facilitation Service', and urgent two week wait referrals for conditions such as cancer were faxed. Referral templates were saved on the computer system for all GPs to access. The practice had reviewed their referral rates which were historically high, and had made changes to improve this. For example physiotherapy exercise leaflets were provided to patients as the waiting time for musculoskeletal referrals was up to 12 weeks; and the practice were utilising community services more. All referrals by locum GPs were triaged by the GP partners to check they were appropriate. However, we reviewed a sample of 41 referrals made by the practice over the last three months and found 11 had sufficient clinical detail about the reason for referral, history of symptoms, and treatment received, and 30 referrals had minimal clinical information. We spoke to the GP partners who agreed they would speak with the other GPs and review the clinical content of future referrals in more detail to improve quality.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. We saw evidence that the GP partners and two nurses had received training in dementia awareness.

Good

Are services effective?

(for example, treatment is effective)

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it.

The practice had a consent policy. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with a nurse to all new patients registering with the practice. Patients aged 16-25 years were offered chlamydia screening during their check-up. The GPs were informed of all health concerns detected during the new patient health check and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years, and practice data showed that 241 patients in this age group had received a health check.

We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering advice on disease management, diet, smoking cessation, and alcohol intake. Health promotion information was available to patients in the waiting room, consulting rooms, and on the practice website.

The practice had ways of identifying patients who needed additional support. For example, the practice kept registers of patients with a learning disability; mental health condition; dementia; and those in receipt of palliative care. These patients received care and further support in line with their needs.

Data from the quality and outcomes framework (QOF) indicated that the practice exceeded the CCG and national averages for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses by achieving 100% (CCG average 86.4%, national average 85.9%). It was also above average for the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months, achieving 100% compared to the local average of 88.1% and national average of 83.8%).

The practice's performance for the cervical screening programme in the preceding year was 76.1%, which was below the local average of 78.6% and national average of 81.9%. Reminders were sent by text message or letter for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for flu vaccinations was either below or above the national averages where comparative data was available. For example, flu vaccination rates for the over 65s was 52.11% compared to the higher national average of 73.24%, and at risk groups was 60.03% compared to the lower national average of 52.29%.

Antenatal and postnatal care was offered as part of a shared care programme with the hospital. The practice nurses provided childhood immunisations. Last year the practice's childhood immunisation rates ranged from 76.9% to 95.2% for children aged under 12 months; 86.7% to 98% for under twos; and 69.1% to 88.2% for five year olds. Performance for childhood immunisations was similar to the CCG averages, for example 90.8% of children aged 24 months had received an MMR vaccination (CCG average 86.4%); and 70.6% of 5 year old children had received the Dtap/IPV Booster (CCG average 67.5%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015 (68 surveys sent back), patient satisfaction surveys carried out by the practice in March 2013 (108 responses received) and January 2014 (150 responses received), and patient feedback received for the GP partners' annual appraisal 2014.

Data from the national GP patient survey 2015 showed that the practice was below the CCG and national averages for patient satisfaction scores on consultations with the GPs. For example, 75% of respondents said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%. Seventy seven percent said the GP gave them enough time compared to the CCG average of 81% and national average of 87%. Satisfaction scores for consultations with the nurses was similar to the CCG and national averages. For example, 91% of respondents said the nurse was good at listening to them (CCG average 86%, national average 91%), and 88% said the nurse gave them enough time (CCG average 88%, national average 92%).

Results from the practice survey carried out in March 2013 showed that 77% of patients said the doctors at the surgery were good, and in January 2014 this figure increased to 80%. The practice surveys did not take into account satisfaction levels for consultations with the nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring and professional service, and the doctors took time to listen to them. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection, and one member of the Patient Participation Group following our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical and non-clinical staff. Patients were particularly complimentary about the continuity of care provided by the GP partners.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy screens were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that a private area within the practice could be used to prevent patients overhearing potentially private conversations between patients and reception staff. Confidential calls were made from the back of the reception office. The national GP patient survey showed that 82% of respondents found the receptionists at the practice helpful compared to the CCG average of 83% and national average of 87%.

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

Care planning and involvement in decisions about care and treatment

The national patient survey 2015 showed that respondents rated the practice similar to or slightly above the CCG average, and slightly below the national average to questions about their involvement in planning and making decisions about their care and treatment. For example, 80% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 81%. Seventy nine per cent said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.

Satisfaction scores for consultations with the nurses showed that 87% said the nurse was good at involving them in decisions about their care (CCG average 80%, national average 85%), and 86% said the nurse was good at explaining tests and treatments (CCG average 85%, national average 90%).

All the 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. Patient feedback on the comment cards we received was also aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. Some staff could also speak languages other than English (such as Arabic, Farsi, Gujarati, Hindi, Punjabi, Sinhalese, Tamil and Urdu), which aided communication with some patients.

Patient/carer support to cope emotionally with care and treatment

The national patient survey showed that 71% said the last GP they spoke to was good at treating them with care and concern compared to the higher CCG and national averages of 79% and 85% respectively. Eighty-five per cent of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the similar CCG average of 86% and higher national average of 90%. Patients we spoke to on the day told us that staff responded compassionately when they needed help and provided support when required.

Staff told us that patients were offered referral to emotional support services such as counselling, community mental health services, and drug and alcohol addiction services. We were also told that patients were signposted to other support organisations, including those for the elderly, for people experiencing domestic abuse, and asylum seekers. None of the patients we spoke with on the day of our inspection or who completed the CQC comment cards mentioned emotional support or treatment however notices in the patient waiting room and on the practice website told patients how to access a number of support groups and organisations.

The percentage of patients with a caring responsibility was lower than the national average at 14.1% compared to 18.2%. The practice's computer system alerted GPs if a patient was a carer, and carers were offered health checks and the flu vaccination. A carer's policy was in place, and information on the various avenues of support for carers was made available in the waiting room.

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 had systems in place to maintain the level of service provided. The GP partners told us that they engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, 22% of patients' first language was an Indian language and we were told there was a significant number of patients who only spoke Hindi and Punjabi. The practice had therefore recruited a receptionist who could speak both these languages to aid communication with these patients. This information was advertised in the practice leaflet and on the website.

The GP partners attended meetings under the 'integrated care pilot' programme which aimed to improve outcomes for patients by creating an integrated approach to care in the community, reduce unnecessary hospital admissions, and enable effective multidisciplinary team work. Patients with complex needs and those identified as 'at risk' were discussed. For example, patients with multiple long-term conditions, and patients with dementia. These meetings were attended by social workers, mental health practitioners, and hospital consultants, to discuss care planning for these patients.

The practice were signed up to the enhanced service for facilitating timely diagnosis and support for people with dementia. Assessment templates were available on the computer system, and patients could be referred for further support at the memory clinic. The GP partners told us that dementia awareness had improved following staff training, and the number of patients with a diagnosis of dementia had increased from three to 15.

The practice had started planning for the 'out-of-hospital services' whereby additional services including phlebotomy and electrocardiograms (ECGs) were offered to patients within the GP practice environment. The practice had reviewed the services they were able to offer their own patients and patients from local practices, and we were told this would come into effect later this year.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the group had suggested having an Indian language speaking receptionist during surgery hours and this had been accommodated. The group had also stated that there was some confusion in identifying which GP they were seeing as there were GPs who had the same surname. The practice had since displayed the full names of the GPs in the waiting room, practice leaflet and on the website, and staff were instructed to give this information over the phone. We spoke to a member of the PPG following our inspection. Their feedback was very positive with regard to how the practice implemented changes following feedback from patients and the PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointments were available for people who may need them, such as those experiencing poor mental health, emotional problems, or patients who required signposting to other support organisations. Staff told us they tried to book these appointments towards the end of a clinical session so that these patients could be given more time if needed and to prevent delays to other patients' appointments.

The majority of the practice population were English speaking patients and access to translation services were available if they were needed. There was a system for flagging vulnerability in individual patient records. For example, to identify patients who were housebound, receiving palliative care, or patients with learning disabilities. All patients over the age of 75 had a named GP and were informed of this in writing.

The premises and services had been designed to meet the needs of people with disabilities. The practice had undergone refurbishment in 2012 and an additional two consulting rooms with disability access had been built. The practice was accessible to patients with mobility difficulties as patient facilities were all on one level. Accessible toilet facilities were available for patients attending the practice and included baby changing facilities. There was a large

Good

Are services responsive to people's needs?

(for example, to feedback?)

waiting area with plenty of space for wheelchairs and prams. Patients could choose to see a male or female GP. The practice had an equality and diversity policy in place and staff received training during their induction.

Access to the service

The practice was open every weekday from 08:30 to 18:30, except Wednesday afternoons when it closed at 13:30. From 08:00 to 08:30 patients who contacted the practice were directed to an out-of-hours GP service. Appointments were available Monday to Friday from 9:00 to 13:00, and 16:00 to 18:30 (except Wednesday). Extended hours were offered on Monday, Tuesday, Thursday and Friday from 18:30 to 19:30. These were particularly useful to patients with work or educational commitments, as the practice had a higher percentage of patients in paid work or full-time education (77.7%) compared to the national average (60.2%). Appointments could be booked in advance over the telephone, online or in person. Text message reminders for appointments were sent to patients. Information was available to patients about appointments in the practice leaflet and on the website. This included how to arrange home visits. A timetable of when clinical staff worked was on display in the waiting room and on the website so that patients could see their preferred GP. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. On Wednesday afternoons and outside of normal opening hours patients were directed to an out-of-hours telephone number, or the NHS 111 service. Information on the out-of-hours service was provided to patients.

Longer appointment times were available for those who may need them including patients with complex conditions; antenatal and postnatal care; and annual reviews for patients with long term conditions. Home visits were made to patients who needed one, including housebound patients, and the frail elderly. A daily telephone surgery was available every day for patients to speak with a GP for matters that did not require attendance. Telephone consultations were also provided to patients who found it difficult to access the practice.

The national patient survey 2015 information we reviewed showed that 89% were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%. However, the practice was rated below average for other questions about access to appointments. For example, 61% described their experience of making an appointment as good compared to the CCG average of 68% and national average of 73%; and 58% said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 73%. The practice told us they were aware that telephone access in the morning was an issue. They were trying to resolve this by informing patients to only call between 08:30 to 09:30 to make same day appointments, and for all other matters such as receiving blood test results to call later.

Most of the patients we spoke with were satisfied with the appointments system and said it was easy to use and they could get an appointment when they needed one, although some stated it was difficult accessing the service by telephone in the mornings. Patients confirmed that they could usually see a doctor on the same day and were aware that this might not be with the GP of their choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the practice manager was the designated responsible person who handled all complaints in the practice. Complaints were discussed in staff meetings, or sooner if required, and staff we spoke with were able to outline what to do if a complaint was made to them. Staff told us that wherever possible they tried to de-escalate problems and deal with concerns immediately.

We saw that information was available to help patients understand the complaints system in the practice leaflet, in the waiting room, and on the website. Some patients we spoke with were aware of the process to follow if they wished to make a complaint, and others told us they would request the information from staff. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found these had been handled satisfactorily and in a timely way. We saw from meeting minutes that complaints were a standing item at the quarterly practice meeting however, we saw evidence that the practice learned from individual complaints and what action they had taken to improve quality of care as a result.

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 GP partners were able to describe the practice's vision and strategy to deliver high quality care and promote good outcomes for patients. This strategy included providing a quality service which was accessible, personal, flexible and responsive to the practice population. Over the last five years the practice had seen its list size increase from around 4,000 to 9,000 patients, and this had had an effect on the capacity of the practice to meet patient demands for appointments and the services it could offer. As a result the practice funded an extension of the premises in 2012, and secured three regular locums GPs and two locum nurses to assist the clinical team. The 'out-of-hospital services' were also a priority for the practice and were incorporated into their strategy. Other staff we spoke with discussed the importance of providing patient-centred care and knew what their responsibilities were in relation to this, however they were not aware of a formalised vision or strategy for the practice. We did not see any information on values displayed within the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in folders within the practice. Staff had completed a cover sheet to confirm that they had read the policy and when. We looked at a number of these policies and procedures, including those relating to chaperoning, confidentiality, consent, safeguarding, infection control, health and safety, complaints, and business continuity. These had been reviewed annually and were up to date, and staff we asked knew how to locate these documents.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP and nurse for infection control; a lead GP for safeguarding; a GP and enhanced services manager to lead on QOF; and the practice manager led on complaints. Staff we spoke with were all clear about their own roles and responsibilities and knew who the various leads were. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. They also felt there were involved in decision making where appropriate.

A GP partner and the enhanced services manager took active leadership roles for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards and had achieved 866.84 points out of a total of 900 for the year 2014. The practice told us that they had maintained their performance in QOF for 2015 by achieving 98.9% (553 out of 559 points) of the total target. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. We reviewed examples of completed audits for referrals, cervical smear tests, and intrauterine contraceptive devices (IUCDs). Evidence from other data from sources, including incidents, significant events and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the clinical commissioning group (CCG).

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. For example, risks relating to business continuity and infection control had been carried out. Whilst fire safety equipment had been checked, the practice had not carried out a fire risk assessment.

The GP partners met informally on a daily basis to discuss governance issues, and more formally during the quarterly practice meeting. Clinical meetings were incorporated into the practice meeting and locum staff were invited to these meetings. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of documents, including an induction policy which was in

Are services well-led?

Good

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

place to support staff. Staff we spoke with knew where to find these policies if required. Staff were aware of the term whistleblowing, however there was no practice policy to support staff if they had concerns.

Leadership, openness and transparency

The partners and practice manager were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff were encouraged to contribute to discussions about how to improve the service delivered by the practice.

We saw from minutes that team meetings were held every three months. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the GP partners.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through practice surveys, complaints received, the national GP patient survey, the Friends and Family test, and the patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The PPG included representatives from various population groups including: older people; people with long-term conditions; and people whose circumstances may make them vulnerable. The PPG carried out annual surveys and met once or twice a year. We saw that the action plan agreed from the 2013 survey had been met. We were shown the analysis of the last patient survey in 2014, and an action plan for 2015 had been developed in conjunction with the PPG. The practice had yet to meet with the PPG this year. We spoke with a member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

The practice also reviewed data from the national GP patient survey 2015 to identify areas they performed well in and areas which required improvement. They developed an action plan based on the 2015 survey to improve areas which were rated low. For example, the national patient survey showed that 46% of respondents said they usually got to see or speak with their preferred GP, compared to the clinical commissioning group (CCG) average of 56% and national average of 60%. The practice told us that a previous GP locum received poor feedback from patients, and this led to a higher patient demand to see other GPs. The practice had since appointed two new GP locums.

The practice had also gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. We also saw that GPs carried out case reviews, which were based on significant events, for their annual appraisal. Staff told us that the practice provided in-house training, and external training was arranged for mandatory courses such as child protection and basic life support.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw from minutes that discussion of significant events and their outcome was a standing item on the agenda of the practice meetings. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings.