Glenlyn Medical Centre

Quality Report

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Date of inspection visit: 19 May 2015
Date of publication: 23/07/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Glenlyn Medical Practice on 19 May 2015. The practice has an overall rating of good.

We found the practice to be good in the effective, responsive, caring and well-led domains. It required improvement in the safe domain due to not have completed and recorded all of the necessary checks required for staff recruitment.

The Glenlyn Medical Practice provides primary medical services to approximately 15,500 patients registered at the practice. The practice is run by a team of two GP partners, a medical director, two associate GPs, salaried GPs, GP registrars and a team of nurses.

The practice had undergone a period of significant change over the last four years with four senior GPs retiring and salaried GPs leaving the practice. The practice had recognised that patients had concerns over continuity of care and access to timely appointments and had plans in place for the future to address these concerns. The practice had recently merged with another practice and had employed a Business Manager to help support the practice and the merger.

The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. The practice understood the needs of the local population and engaged effectively with other services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice was open Monday to Friday 8am to 8pm and offered Saturday morning appointments

Summary of findings

- Patients told us they did not always find it easy to make an appointment or have appointments with a named GP. However, they had been able to access urgent appointments on the same day.
- Most said the GPs were helpful and caring but there was lack of continuity of care due to not being able to see the same GP
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had a firm commitment to training and staff were committed to maintaining and improving their skills and abilities to carry out their roles.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly, the provider must:

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process, including a risk assessment as to which staff required a criminal records check with the disclosure and barring service (DBS).

The provider should:

- Continue to review and implement improvements to patients' access to the practice
- Ensure the chaperone policy indicates only staff who have been risk assessed and trained can be used as chaperones

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Audits, significant events and complaints were reviewed and learning discussed with clinical staff. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. However, recruitment checks required were not always documented and there was no risk assessment as to which staff required a criminal records check with the disclosure and barring service (DBS). Staff told us they routinely asked if patients would like a chaperone for intimate examination and we saw information on display offering this service. There were enough staff to keep patients safe. The practice was clean and tidy and appropriate hygiene standards were maintained. Emergency procedures were in place to respond to medical emergencies. In the event of an emergency the practice had policies and procedures in place to help with the continued running of the service.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients had a named GP which allowed for continuity of care. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with local multidisciplinary teams to provide patient centred care.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with

Summary of findings

kindness and respect, and maintained confidentiality. During the inspection we witnessed staff interacting with patients in a way that was respectful and friendly. The practice advertised local support groups so that patients could access additional support if required.

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 NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients told us they did not always find it easy to make an appointment with a named GP. However, they had been able to access urgent appointments on the same day. 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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was in the process of being re-organised due to a recent merger with another practice. Staff we spoke with told us they felt valued and were appreciated. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns.

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 had a named GP which allowed for continuity of care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. Elderly patients with complex care needs all had personalised care plans that were shared with local organisations to facilitate the continuity of care. The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medicine needs were being met. The GPs followed national guidance for reviewing all aspects of a patient's long term health. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice nurses were trained and experienced to support patients with managing their conditions and preventing deterioration in their health. The local clinical commissioning group had funded a specialist diabetic nurse to offer support and training to the practice to increase clinician's knowledge. Diabetic patients were supported by the practice in managing their condition and were encouraged to monitor their own condition and set health goals. The practice had a specialist respiratory nurse who managed all asthma and chronic obstructive pulmonary disease (COPD) patients. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Monthly meeting were held with health visitors to discuss any children of concern. Immunisation rates were average for the local clinical commissioning group (CCG) area. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments would be seen on the day.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. For example, the practice was open Monday to Friday 8am to 8pm and offered Saturday morning appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered advice on diet and weight reduction. Nurses were trained to offer smoking cessation advice and patients could request routine travel immunisations.

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 for example those who were housebound or with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. It offered longer appointments for patients when required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Translation services were

Summary of findings

available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Carers and those patients who had carers were flagged on the practice computer system. A member of staff was a carer's support link worker who worked closely with Surrey Carer Support Programme and could provide information or signpost carers to local support teams and networks.

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). Patients with severe and enduring mental health needs had care plans and received annual physical health check. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice participated in the Dementia Direct Enhanced Service which ensures early diagnosis of Dementia. Patients were referred to a dementia nurse for consultation following a blood test and could then be referred to the local elderly mental health team. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 16 comment cards which contained mixed comments about the practice. We also spoke with nine patients on the day of the inspection.

The results of the national patient survey carried out in 2014 showed that patients were not as positive about their views of Glenlyn Medical Practice compared to other practices within the clinical commissioning group area. The survey showed that 90% of patients gave a positive rating when asked if the nurses were good at explaining tests and treatments and 91% said they felt they were good at listening to them. 79% of patients said they found it easy to get through to the surgery by phone however, only 29% said they got to see or speak with their preferred GP. When asked if patients had trust in their GP 88% agreed and 72% said they felt the GP listened to them. The survey had been completed by 114 patients.

The practice provided us with a copy of the practice patient survey results from 2014. The survey was conducted in light of the recent changes within the practice and from patient feedback. The survey asked six questions and 173 patients responded. When asked how patients rated the service of the duty doctor 84% said they felt it was adequate to excellent. When asked about the extended openings hours (8am to 8pm with Saturday morning appointments) only 11 patents felt this service was poor. Results showed that only 16 patients felt that telephone consultation appointments were poor and 97% thought that text communication for tests result was adequate to excellent. When asked if patients felt that GP retention had stabilised 46% felt that it was better and 17% thought it was back to how it previously was. When asked if the administration team were more attentive to patients' needs 78% said it had improved, was good or excellent.

We spoke with nine patients on the day of the inspection and reviewed 16 comment cards completed by patients in the two weeks before the inspection. Both the comments we reviewed and the patients we spoke with had mixed views about the practice. Most thought that practice staff were caring and professional. They told us they did not feel rushed in appointments and that things were always explained well to them. One person told us that they were able to have convenient appointments for their children and several told us they had accessed emergency appointments on the same day. However, we also received negative comments in relation to access of appointments and the continuity of care by seeing the same GP.

Areas for improvement

Action the service MUST take to improve

- Ensure that all recruitment checks are carried out and recorded as part of the staff recruitment process, including a risk assessment as to which staff required a criminal records check with the disclosure and barring service (DBS).

Action the service SHOULD take to improve

- Continue to review and implement improvements to patients' access to the practice
- Ensure the chaperone policy indicates only staff who have been risk assessed and trained can be used as chaperones

Glenlyn Medical Centre

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 a Practice Manager specialist.

Background to Glenlyn Medical Centre

The Glenlyn Medical Practice offers personal medical services to 15,500 patients registered at the practice.

The practice has undergone a period of significant change over the last four years with four senior GPs retiring and salaried GPs leaving the practice. The practice has recognised the concerns raised by patients over continuity of care and access of timely appointments and has future plans to address these concerns. The practice has recently merged with another practice and has employed a Business Manager to help support the practice and the merger.

The practice is run by two partner GPs, a medical director, with two associate GPs, four salaried GPs and two GP registrars (doctor in training). The practice is also supported by two advanced nurse practitioners, five practice nurses and four health care assistants. There is a team of receptionists, administrative staff, and an administration management team. (A nurse practitioner is a registered nurse who has completed advanced coursework and clinical education beyond that required of the registered nurse role).

Appointments were available from 8am to 8pm Monday to Friday and pre-bookable appointments on a Saturday morning from 7.30am to 11.20am.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, smoking cessations and warfarin clinics.

Services are provided from:

115 Molesey Park Road, East Molesey, Surrey, KT8 0JX

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

The practice population has a slightly higher number of patients between 30 and 44 years of age than the national and local CCG average. The number of patients aged between 10 and 29 years of age were slightly below the national and local CCG average. There are a lower number of patients with long term health conditions and health-related problems in daily life. The practice serves a population which is more affluent than the national average.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out this comprehensive inspection of the practice, on 19 May 2015, under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the

Detailed findings

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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the Surrey Downs Clinical Commissioning Group (CCG). We carried out an announced visit on 19 May 2015. During our visit we spoke with a range of staff, including GPs, registrars, practice nurses and administration staff.

We observed staff and patients interaction and talked with nine patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 16 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the medical director had identified a medicine that should be closely monitored by blood tests. This was discussed at a practice meeting and following an audit of patients on this medication it was noted that only 63% of patient had been correctly monitored. The patients were notified and the asked to come in for a review. The audit was completed again six months later and 100% of patients were now being correctly monitored.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. 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 viewed records of significant events that had occurred during the last 12 months. Significant events were a standing item on the practice meeting agenda where actions and learning points were reviewed. 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.

GP and nurses were able to describe their involvement in significant events and incidents which had taken place and the learning involved. We noted that records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, the hospital pharmacy had noted an error on a patient's prescription where it was indicated that they should be taking a medicine twice daily which was double the required amount. The patients' GP contacted the patient to apologise and discuss the error however; the patient had been aware of the correct dosage and had been taking the required amount. After investigating it was noted that the computer system for generating prescriptions automatically reverted to this medicine being taken twice daily when prescribed initially. The issue was discussed at the weekly clinical meeting and the emphasis on reviewing new medicine prescriptions. It was also discussed with the area lead for anticoagulation prescribing as potentially this could be a national problem with the computer system.

National patient safety alerts were disseminated to practice staff and discussed at the doctor's daily meetings as well as the weekly clinical meetings. Actions required were documented in the minutes of the meeting which showed that actions had been identified and followed through. Staff we spoke with were 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 on safeguarding. 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.

The practice had appointed two dedicated GPs as the lead in both safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans.

There was a chaperone notice, which was visible on the waiting room noticeboards and in consulting rooms. (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). Nursing staff, including health care assistants, could be required to act as a chaperone and understood their responsibilities, including where to stand to be able to observe the examination. We noted that the chaperone policy wrongly indicated that administrative staff could act as chaperone. We spoke with administrative staff and the business manager in relation to this. They informed us that only clinical staff were asked to perform chaperone duties and that the policy would be updated.

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. Staff ensured that medicines stored within refrigerators were kept at the required temperatures, and could describe the action to take in the event of a potential failure.

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. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that the nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, we saw evidence of patients who were taking a particular medication receiving a blood test at the required intervals in line with guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. All communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor. We saw cleaning schedules in place which specified the cleaning requirements and frequencies and completed cleaning records were kept.

The practice had a lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed on time.

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.

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

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment

maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of September 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, and blood pressure measuring devices. The nurse practitioner carried out regular checks on emergency equipment such as the oxygen and defibrillator.

Staffing and recruitment

Records we looked at did not all contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, some files did not contain CV's or job applications, references from past employers, a full works history which included months and years, an investigation into gaps in employment and reasons for leaving past employers. There was also no written risk assessment as to why administration or reception staff had not received a criminal record check via the Disclosure and Barring Service (DBS). The practice had a new recruitment and selection policy that set out the standards it would follow when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including 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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, patients with long term conditions that had a sudden deterioration in their health had care plans reviewed and were visited in their homes if needed. We also noted that systems were in place to respond to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff were able to give an example where they had responded to an emergency within the practice.

An emergency and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure and access to the building. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

GPs and nurses we spoke with were open about asking for and providing colleagues with advice and support. GPs told us that they met every day and used this time to support each other and to review and discuss new best practice guidelines.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. Patients with specific needs were reviewed to ensure they were receiving appropriate treatment and regular review. For example, blood pressure monitoring. The practice took part in the avoiding unplanned admissions scheme. The GPs discussed patient's needs at monthly clinical meetings and ensured care plans were in place and regularly reviewed. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, clinical reviews and medicines management. The information staff collected was then collated by the assistant practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

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). For example, we saw an audit regarding the prescribing of an antibiotic medicine. Following the audit, the GPs carried out a medicine reviews for patients who were prescribed this medicine and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 91% of patients with diabetes had a record of retinal screening in the preceding 12 months and 97% had received the influenza immunisation. We also noted that 91% of patients with a mental health concern (schizophrenia, bipolar affective disorder and other psychoses) had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate and 92% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional, including an assessment of breathlessness in

Good

Are services effective?

(for example, treatment is effective)

the preceding 12 months. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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

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

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. Patients were also highlighted on the practice computer system so that their care could be prioritised.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, safeguarding children and vulnerable adults. The practice was closed for half a day three times a year to accommodate training that was organised by the local Clinical Commissioning Group. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. One of the nurses we spoke with told us they felt their appraisal with a partner GP was a two way process and felt it was a positive experience. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the administrative staff we spoke with told us they had been approached to take on extra training in order to become a healthcare assistant. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Relevant staff were aware

Good

Are services effective?

(for example, treatment is effective)

of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. We noted that the practice held monthly palliative care meetings and separate health visitors meetings. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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. Electronic systems were also in place for making referrals, and the practice made some referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Information about this was available on the practice website and patients are given the opportunity to opt out of the process. Patients were discussed between the practice GPs, practice nurses and other health and social care professionals. All the GPs met regularly to discuss the care and treatment of patients who used the practice.

There was a practice website with information for patients. The website told patients about the services offered by the practice and signposted them to services available and latest practice news. The business manager told us that a regular patient newsletter was produced quarterly but due to the recent merger with another practice they were ensuring that patients were given as much information as possible in relation to this. We saw that the most recently newsletter which contained information about the merger had been placed at the reception desk and on waiting room chairs for patients to read and take away.

Consent to care and treatment

Staff demonstrated knowledge and understanding of consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005 and their duties in fulfilling it. Systems were in place to support patients to make decisions. Clinical staff demonstrated an understanding of Gillick competencies, which help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions for example, minor surgical procedures, by signing a consent form. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English. We saw that the patient or parent signed the consent form to confirm that the need for surgery and the risks involved had been clearly explained. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. There was evidence that care plans were appropriately reviewed and that they contained details of

Good

Are services effective?

(for example, treatment is effective)

the patient's references for treatment and decisions. Data we reviewed showed that 84% of patients diagnosed with dementia had their care reviewed in a face-to-face review in the preceding 12 months which was in line with the national average**.**

Health promotion and prevention

The practice offered a health check to all new patients registering with the practice. Any health concerns detected were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers. The practice was in the process of offering NHS Health Checks to all its patients aged 40 to 75 years by training a healthcare assistant to perform this role.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with long term conditions and offered an annual physical health check. The practice had also identified the smoking status of 90% of patients over the age of 16 (which was above the national average) and 87% of those patients had a record of an offer of support and treatment within the preceding 24 months.

The practice's performance for cervical smear uptake was 79%, which was comparable with other practices nationally. There was a mechanism of following up patients who did not attend such as reminder letters and telephone reminders for patients who did not attend for cervical smears.

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 all immunisations was around average for the Clinical Commissioning Group, and again there was a clear policy for following up non-attenders.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions. The practice had a Body Mass Index (BMI) machine within one of its waiting room. The BMI is an attempt to quantify the amount of tissue mass (muscle, fat, and bone) in an individual, and then categorize that person as underweight, normal weight, overweight, or obese based on that value. Patients were encouraged to us the machine and discuss the results with their GP.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. Data from the national patient survey showed that 65% of patients rated their overall experience of the practice as good which was slightly lower than the national average score of 68%. The practice was also slightly lower than average for its satisfaction scores on consultations with doctors, with 72% of practice respondents saying the GP was good at listening to them and 71% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 88% of patients had responded that they had confidence and trust in the last GP they saw or spoke to. When asked the same questions in relation to the nurses 91% of practice respondents said the nurse was good at listening to them and 93% said the nurse they saw or spoke to was good at giving them enough time. We also noted that 90% said the nurses were good at explaining test results, 99% said they had trust and confidence in the nurse and 89% were good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards and had mixed views. Most said the GPs were helpful and caring but there was lack of continuity of care due to not being able to see the same GP. Patients we spoke with told us they felt staff treated them with dignity and respect.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which also helped keep patient information private. The waiting areas were also situated away from the reception desk and an automated booking in system was in use to allow for greater privacy.

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 senior team members. There was a clearly visible notice stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

We reviewed the results of the GP national patient survey from 2014. This showed patients' satisfaction rates to questions about the GPs' involving them in decisions about their care and treatment were just below average when compared with the national average. For example, data from the national patient survey showed 62% of practice respondents said the GP involved them in care decisions; this was below the Clinical Commissioning Group (CCG) average of 74%. Only 65% of patients at the practice felt the GP was good at explaining tests and treatment, again this was below the CCG average of 82%. We saw that patients rated their involvement in making decisions with practice nurses highly. For example 75% of patients felt the nurse was good at listening to them, this was higher than the CCG average of 66% and 90% they were good at explaining tests and treatments with the national average being 76%.

Most patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. This was echoed in some of the comment cards we received.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website also had the functionality to translate the practice information into approximately 90 different languages. Staff within the practice were able to give examples of how they supported individual patient needs in order to promote equality. For example, three different languages were spoken across the practice team who could provide support to individual patients.

Patients were supported to make decision in their care and treatment through use of care planning. At risk patients

Good

Are services caring?

and those with long term conditions had agreed care plans. These were jointly agreed by the patient and the GP. We saw evidence that these were reviewed yearly or more regularly if needed.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting rooms and on the practices website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw information was available for carers to ensure they understood the various avenues of support available to them. A member of staff was a carer support link person and worked closely with the Surrey Carer Support programme to provide information on all aspects of help available.

Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. A GP told us that they would provide support as required and knew organisations to signpost patients where higher level emotional support could be offered.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice management team were aware that there had been concerns from patients about access to appointments. Steps had been taken to address the issues, including regular reviews and trials of various appointment systems to meet demand. The practice had tried several ideas including triage systems to help but felt that previous systems had not alleviated the pressures. The practice now offered an 8am till 8pm appointment system with pre-bookable appointments available Saturday mornings. Appointments could be booked by phone, on line or in person. Patients could request a telephone consultation with a GP instead of attending the practice. The practice also provided extended hours nurse appointments which allowed for working people with long term conditions to attend regular reviews outside of commuting hours. For example, diabetic and asthma annual reviews. The nurses also offered appointments for smoking cessation advice and travel advice outside commuting hours.

The practice provided a named GP and extended appointment slots for patients aged over 75 years and patients classed as 'at risk' of unplanned hospital admission. Home visits were available and patients were also able to leave messages with reception requesting that a GP call them back. The practice also provided care and treatment to patients living in eight local nursing homes.

The practice had male and female GP's and patients could choose to see either. The practice offered a range of services to meet the needs of its patient groups. These included ante natal clinics, sexual health clinics and smoking cessation advice. The practice ran an eight week baby clinic which incorporated an immunisation clinic so that parents did not need to attend the practice twice. Nurses were available on Saturday morning for contraceptive advice and sexual health advice for the young adults. The practice had a specialist respiratory nurse who managed all asthma and chronic obstructive pulmonary disease (COPD) patients and the local clinical commissioning group had funded a specialist diabetic nurse to offer support and training to the practice to increase clinician's knowledge.

The practice had gone through a period of change with senior GPs retiring and salaried GPs leaving the practice. This had meant that patients felt they had not received continuity of care. In response to this the partner GPs had employed more doctors and put in place a formal promotion / support structure in order to retain good quality staff. The practice had asked patients to complete a survey to see if they felt that GP retention had stabilised over the last year, with 63% of patients thinking it was back to normal or better

The practice had also merged with another practice the month before our inspection and was in the process of changing the ways that services were offered in order to provide more appointments for patients with complex care issues and those requiring on the day appointments. This idea had been discussed with NHS England and the local MP in response to concerns raised from patient in relation to appointments and continuity of care. The practice would begin to offer an 'Urgent Care Service' for on the day appointments at the second location. This would allow more pre-bookable appointments to be available and the practice estimate it would provide an extra 100 appointments a day for both locations. This new structure for appointments was being widely advertised throughout the practice and was included in the surgery newsletter and on the practice website.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Only a small minority of patients did not speak English as their first language. Staff told us that usually the patient was accompanied by a family member or friend who would translate for them. There were arrangements in place to access telephone interpretation services for urgent appointments or receptionists could book an interpreter to accompany patients where appointments were booked in advance. We noted information was on display for patients in relation to zero tolerance to abuse.

The practice was situated on the ground and first floors of a building which had been adapted to meet patients' needs. To gain access to the practice there were doors with an automatic opening mechanism and there was lift access to the first floor. We noted there was a lower section in the reception desk to accommodate patients who used wheelchairs.

Waiting rooms were allocated in four areas of the building and all were large enough to accommodate patients with

Good

Are services responsive to people's needs?

(for example, to feedback?)

wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Several chairs had arm rests to aid patients when getting up from their seats. Accessible toilet facilities were available for all patients attending the practice.

Patients with poor mobility were provided with information of a volunteer based community charity who could provide transport services to the practice.

Access to the service

Appointments were available from 8am to 8pm Monday to Friday and pre-bookable appointments on a Saturday morning from 7.30am to 11.20am. Staff told us patients could opt in to receive reminders by text message of an upcoming appointment and or test results.

There was comprehensive information available to patients about appointments on the practice website and in their practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits could be arranged and GPs visited several local residential homes.

Patients were generally dissatisfied with the appointments system. Comments received from patients showed that they had to wait weeks for a routine appointment. Patients we spoke with confirmed that they could see a GP on the same day if they needed to but had to wait to see the GP of their choice. They told us that they felt this meant they did not always receive continuity of care. Some patients indicated it was difficult to get through to the practice by telephone to make an urgent appointment particularly when the practice first opened in the mornings. We noted data from the national patient survey 2014 which indicated that 71% of patients found it easy to get through to the practice by phone which was in line with the national average and that 82% of respondents said the last appointment they received was convenient**.**

The practice was putting in place new plans to have an 'Urgent Care Service' provided to patients for on the day emergency appointments from a practice that they had merged with. This would allow GPs at the practice to have more pre-bookable appointments and would help with appointment pressures and continuity of care.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. We saw that information was in the practice leaflet and on the practice website. However we noticed that there was no information on display in the waiting area. We noted that NHS choices had received complaints from patients that had not been replied to. We spoke with the new business manager in relation to this who was aware of the situation and was in the process of responding to these.

Some of the patients we spoke with told us they had complained to the practice. We did not look at these complaints specifically but reviewed a random selection of complaints over the last 12 monthly. We found these were handled in a timely way with openness and transparency. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff. Complaints were reviewed at the GPs weekly and monthly meetings and the medical director was responsible for any clinical complaints.

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 staff we spoke with told us that they felt well led. All the staff we spoke with told us there was a no blame culture in the practice and they felt that senior staff members were always available to talk with. The practice was clinically well led with a core ethos to deliver high quality care and promote good outcomes for patients. The practice's statement of purpose included the statement to consult with patients concerning their care and explain the pathways and help offered and to serve the practice population as one would wish to be served one's self.

We spoke with 18 members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these. Some of the staff had worked at the practice for a number of years and spoke very positively about the practice. They told us there was good team work and they were actively supported to provide good care for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of the policies and procedures and found they were up to date and held relevant information for staff. This included the confidentiality protocol, infection control and the whistleblowing policy.

There was a clear leadership structure with named members of staff in lead roles. For example, the medical director was the lead for clinical complaints and significant events, a lead nurse for infection control and two GPs were the lead for safeguarding adult and children. We spoke with 18 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, it had recognised that a particular medicine should be closely monitored by the patient receiving blood tests at recommended intervals. This was discussed at a practice meeting and following an audit of patients on this medication it was noted that only 63% of patient had been correctly monitored. The patients were notified and the asked to come in for a review. The audit was completed again six months later and 100% of patients were now being correctly monitored.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a recent risk assessment for health and safety and for infection control.

The practice held regular meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings.

Some staff we spoke with felt that due to the new merger they were not aware of all developments that were taking place. They told us that if they had questions the senior management would always answer them but felt that communication could be better facilitated. We spoke with the business manager and GP partners in relation to this, who had already recognised this as a concern and was putting measures in place so that staff were more aware of the practices developments.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen. Staff told us they felt that the partners encouraged staff to identify opportunities to improve the service delivered by the practice. The partners had put in a place formal promotion and support structures for the GPs in order to retain good quality staff.

We noted that informally the GPs meet every day. They told us this allowed for open discussions to be had as needed to support each other. We saw from minutes that formal meetings were held regularly and there were weekly and monthly management / clinical meetings. Staff told us that

Are services well-led?

Good

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

there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time. It was recognised that administrative staff meetings needed to be more frequent and the business manager was putting into place a meeting schedule.

We saw that human resource policies and procedures were in place to support staff. Staff told us they had access to a staff handbook and knew where to find these policies if required. The hand book included sections on health and safety, equal opportunities and safeguarding. We were also shown the health and safety policy that was available to all staff.

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

The practice gathered feedback from patients through the national patient survey and local surveys undertaken in conjunction with the patient participation group PPG. Complaints were also reviewed and used to inform improvements in the way services were delivered. GPs and the business manager were aware that the responses to the last national survey had not been as positive as in the past. Action had been taken to recruit new GPs and review the availability of GP appointments in response to the concerns shown. The patient participation group (PPG) was in the process of being re-organised due to a recent merger with another practice.

The practice provided us with a copy of the practice patient survey results from 2014. The survey was conducted in light of the recent changes within the practice and from patient feedback. The survey asked six questions and 173 patients responded. When asked how patients rated the service of the duty doctor 84% said they felt it was adequate to excellent. When asked about the extended openings hours (8am to 8pm with Saturday morning appointments) only 11 patents felt this service was poor. Results showed that only 16 patients felt that telephone consultation appointments were poor and 97% thought that text communication for tests result was adequate to excellent. When asked if patients felt that GP retention had stabilised 46% felt that it was better and 17% thought it was back to how it previously was. When asked if the administration team were more attentive to patients' needs 78% said it had improved, was good or excellent.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, one of the nurses had recommended that the practice purchase a Doppler ultrasound which it had done. (A Doppler ultrasound is a non-invasive test that can be used to estimate your blood flow through blood vessels).

All staff were aware of the whistleblowing procedure and we noted that information was on display for staff. There was also a whistleblowing policy which was available to all staff via any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had guest speakers attend the practice to discuss topics. For example, a health visitor had recently held a discussion regarding vitamin D. We saw that new staff had a formal induction programme which involved the new member of staff shadowing other staff members.

We saw evidence that staff had access to learning and development opportunities. Staff told us that the practice was very supportive of their training needs. For example, a receptionist had informed us they had been approached to further train as a health care assistant. We saw that nurses and GPs kept their continuing personal development up to date and attended courses relevant to their roles and responsibilities. The practice was a GP training practice and supported new registrar doctors in training. At the time of the inspection the practice had two registrar GPs. Registrars were supported in their role by experienced, trained GPs and received supervision and mentoring throughout their period in the practice. We spoke with a GP in training and they told us they received good support from their trainer and from the practice team.

Staff we spoke with told us and we saw evidence of protected learning events throughout the year. These were a combination of training designed by the clinical commissioning group (CCG) and internal training / updates from the practice. The practice was closed for these events and patient queries and appointment times were covered

Are services well-led?

Good

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

by the Out of Hours provider. The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Some information (references, explanations of gaps in employment, full works history, reason for leaving) specified in Schedule 3 of the Health & Social Care Act 2008 in respect of people employed for the purposes of carrying on a regulated activity was not available. This was in breach of Regulation 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.