East Barnwell Health Centre

Quality Report

East Barnwell Health Centre
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We visited East Barnwell Health Centre on the 22 June 2015 and carried out a comprehensive inspection. We found that the practice provided a safe, effective, caring, responsive and well led service. The overall rating for this practice is good.

We examined patient care across the following population groups: older people; those with long term medical conditions; families, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups.

Our key findings were as follows:

- The practice had a GP led telephone triage service. Patients were able to get an urgent appointment the same day, if they needed to be seen urgently.
- Patients were treated with dignity, care and respect. They were involved in decisions about their care and treatment. Information was provided to help patients understand the care available to them.
- The practice was friendly, caring and responsive. It addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- The practice had responded to the needs of their patient population. They had a number of initiatives which directly impacted positively on the specific needs of their patient population. These included initiatives to improve health inequalities.
- The clinical leadership at the practice was forward thinking and supportive.

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

Summary of findings

- Ensure that they have documented assurance from external agencies that identified checks and work had been undertaken. This included for example cleaning records, spot checks of cleaning and Disclosure and Barring Service checks for locum staff.
- Improve the follow up of vulnerable patients who did not attend for their appointment.
- Improve arrangements for providing patients with information about the complaints process, in particular including how to escalate complaints if they remained dissatisfied.
- Ensure that all policies are dated and reviewed.
- Improve the security within the practice, so that patients do not have unauthorised access to medicines, blank prescription forms or confidential patient information.

We saw two areas of outstanding practice, which included:

- The practice had obtained funding from the Evelyn Trust for a long term condition nurse to work specifically with patients between the aged of 16 and 65 for one year. This service had been running for approximately three months and positive patients outcomes had been identified. These included a reduction in GP time and hospital admission and verbal feedback from patients had been extremely positive.
- The practice was proactively working with the Citizens Advice Bureau (CAB) on a one year project to test the impact of CAB advice delivered as a front line health service. The aim is to measure the impact on patients, for example, patients reporting less stress, less need to attend the GP practice and less time that health professionals spend on patients with non-medical problems. The service is funded for three days a week and is already being well used.

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. When things went wrong these were investigated to help minimise reoccurrences. Lessons were learnt and communicated widely to support improvement. The provider had identified the need to ensure that identified actions from significant events had been completed and had a plan in place for doing this. Information about safety was recorded, monitored, appropriately reviewed and addressed. However the practice could not always provide assurance that checks and work had been undertaken by external agencies. Risks to patients were assessed and managed. Patients, including children, who were identified as being at risk, were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe. Premises were clean and risks of infection were assessed and managed. The practice had suitable equipment to diagnose and treat patients. Medicines were stored and handled safely, however the security within the practice could be improved.

Are services effective?

Good

The practice is rated as good for effective. Data showed the majority of patient outcomes were average or above for the locality. National Institute for Health and Care Excellence (NICE) guidance and other best practice guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. We saw evidence of effective multidisciplinary working. There was an effective induction programme for new staff to the practice. Staff had received training appropriate to their roles and further training needs had been identified and planned for. Staff had received annual appraisals.

Are services caring?

Good

The practice is rated as good for caring. National data showed patients rated the practice average or slightly below average compared to others in the locality for several aspects of care. Where data had been below average for the locality, action had been taken to ensure improvement. Patients we spoke with and received comments from told us they were treated with compassion, dignity and respect. They were listened to by all staff and involved in care

Summary of findings

and treatment decisions. Feedback from representatives of patients was positive. Accessible information was provided to help patients understand the care available to them. We also observed that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed and addressed the needs of their local population. They had successfully applied for additional funding for a long term condition nurse for patients aged between 16 and 65 years for a one year pilot. They had worked with the Citizen's Advice Bureau who were funded for three days a week, to support patients with issues that were not medical in nature and address health inequalities. The majority of patients reported satisfaction with the appointments system. They had access to telephone consultations, urgent appointments available the same day and home visits. They were well equipped to treat patients and meet their needs. There was an accessible complaints system, but not all patients were informed of how to escalate their complaint if they were dissatisfied with the response from the practice.

Are services well-led?

Good

The practice is rated as good for well-led. There were aims and objectives in place and staff were aware of their responsibilities in relation to these. The practice was a training practice for qualified doctors who were training to be GPs. They also supported other practices in the local area. There was strong clinical leadership and staff we spoke with felt supported in their work. The practice had a number of policies and procedures to govern its activity, although not all of the policies had been dated and reviewed. Regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff attended staff meetings and peer support meetings and received annual appraisals.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. The practice offered proactive, personalised care to meet the needs of the older patients in its population. The practice was responsive to the needs of older patients, including offering home visits. Patients who had unplanned admissions to hospital were reviewed and appropriate support provided. The most vulnerable patients had a care plan in place and were reviewed every three months.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice had successfully applied for funding and had a long term condition nurse for one year to focus on the needs of patients between the age of 16 and 65 years. This service had been running for approximately three months and positive patients outcomes had been identified. These included a reduction in GP time and hospital admission and verbal feedback from patients had been extremely positive. All patients with long term conditions had structured reviews, at least annually, to check their health and medication needs were being met. For those patients with the most complex needs the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care. A Diabetes support group was held monthly at the practice. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. A midwife led clinic was available for patients on a weekly basis. A health visitor clinic for babies was held weekly and for toddlers, was held monthly. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. We saw good examples of joint working with midwives, health visitors and school nurses.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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. Patients who worked were offered appointments between 5pm to 6pm, but if this was not convenient the GPs told us they would see patients before and after surgery. Patients could also request a specific time for the GPs to phone them back for a telephone or telephone triage consultation. A full range of health promotion and screening which reflects the needs for this age group was also available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Nationally reported data showed the practice performed above the Clinical Commissioning Group (CCG) and England average for people with a learning disability. The practice held a register of patients with a learning disability and 50% had received an annual health check in the previous year. The practice sent a letter to vulnerable patients who did not attend for their appointment. The practice manager informed us that this was an area that they would further improve. Longer appointments were given to patients who needed more time to communicate during a consultation, for example patients who needed an interpreter. There were arrangements for supporting patients whose first language was not English. They had worked with the Citizen's Advice Bureau who were funded for three days a week, to support patients with issues that were not medical in nature and address health inequalities. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Nationally reported data showed the practice scored above the Clinical Commissioning Group (CCG) and England average for patients with mental health needs and those with dementia. The practice had participated in a Clinical Commissioning Group and a national initiative to identify patients with dementia. Registers were held of patients with mental health needs, including those with dementia. 89% of patients with dementia had received an annual

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health check in the previous year. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. Patients were referred to other mental health services as appropriate, including in house counselling held at the practice and the improving access to psychological therapy (IAPT) service.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection. The majority of the patients told us that they were able to get an appointment easily and on the same day, if their need was urgent. They reported that they had sufficient time with the GP and nurses and were not rushed during their consultation. Patients were complimentary about the care and treatment they received. They confirmed they were involved in their care and treatment decisions, were offered chaperones and were aware of how to complain. They also reported a good experience with getting repeat prescriptions and having their medicines reviewed.

Our comments box was displayed at the practice and comment cards had been made available for patients to share their experience with us. We collected 12 Care Quality Commission comment cards. The majority of the comments on the cards were positive about the practice. This included the clinical care and follow up they received. Patients reported that all the staff were friendly, helpful and caring. They found the surgery clean and reported feeling safe at the practice. Most of the patients reported that they were able to get an appointment easily, although two patients were dissatisfied with the wait for a routine appointment.

We spoke with two representatives from sheltered housing accommodation, where patients were registered with the practice. They were complimentary about the service provided by the GPs and the speed of attendance in response to home visit requests. They reported that patients were treated with dignity and respect and their confidentiality was maintained. Patients were given a choice of a male or female GP, which they liked. We were told that patient consent was obtained when this was needed and that patients were involved in decisions about their care and treatment.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that they have documented assurance from external agencies that identified checks and work had been undertaken. This included for example cleaning records, spot checks of cleaning and Disclosure and Barring Service checks for locum staff.
- Improve the follow up of vulnerable patients who did not attend for their appointment.
- Improve arrangements for providing patients with information about the complaints process, in particular including how to escalate complaints if they remained dissatisfied.
- Ensure that all policies are dated and reviewed.
- Improve the security within the practice, so that patients do not have unauthorised access to medicines, blank prescription forms or confidential patient information.

Outstanding practice

- The practice had obtained funding from the Evelyn Trust for a long term condition nurse to work specifically with patients between the aged of 16 and 65 for one year. This service had been running for approximately three months and positive patients outcomes had been identified. These included a reduction in GP time and hospital admission and verbal feedback from patients had been extremely positive.
- The practice was proactively working with the Citizens Advice Bureau (CAB) on a one year project to test the impact of CAB advice delivered as a front line health service. The aim is to measure the impact on patients, for example, patients reporting less stress, less need to attend the GP practice and less time that health professionals spend on patients with non-medical problems. The service is funded for three days a week and is already being well used.

East Barnwell Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP Specialist Advisor. The team also included a practice manager specialist advisor.

Background to East Barnwell Health Centre

East Barnwell Health Centre, in the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area, provides a range of general medical services to approximately 7000 registered patients living in East Barnwell and the East side of Cambridge.

According to Public Health England information, the patient population has a slightly higher than average number of patients aged 0 to 18 compared to the practice average across England. It has a significantly lower number of patients aged 65 and over and a slightly lower number of patients aged 75 and over and aged over 85 compared to the practice average across England. Income deprivation affecting children is slightly above average and in relation to older people is slightly lower than the practice average across England. A slightly lower percentage of patients had a caring responsibility and had a long standing health condition compared to the practice average across England.

There are four GP partners, two male and two female who hold financial and managerial responsibility for the practice. There are two salaried GPs, two practice nurses, a nurse practitioner (who is working at the practice for one year to care for people with long term conditions), a health care assistant and a phlebotomist. There are also receptionists, administration staff and a practice manager. The practice is a training practice for medical students and qualified doctors who are training to be GPs. They currently have three GP Registrars.

The practice provides a range of clinics and services, which are detailed in this report, and operates between the hours of 8.30am and 6.00pm, Monday to Friday. Outside of practice opening hours a service is provided by another health care provider Urgent Care Cambridgeshire.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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

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

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed

Detailed findings

information we had received from the service and asked other organisations to share what they knew about the service. We talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch. The information they provided was used to inform the planning of the inspection.

We carried out an announced inspection visit on 22 June 2015. During our visit we spoke with a range of staff, including GP partners, a salaried GP, a GP Registrar, nurses, reception and administration staff and the practice manager. We spoke with two members of the patient participation group (PPG). This is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We also spoke with ten patients who used the practice. We reviewed 12 comments cards where patients had shared their views and experiences of the practice. We spoke with two representatives from sheltered housing, where patients were registered with the practice.

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

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

We also 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)

Good

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. There were records of significant events that had occurred since 2009 and we were able to review these. One significant event involved a medication being prescribed inappropriately. The practice had put an alert on the computer to prompt the prescriber to double check the prescription was correct. There were other examples to show that learning had taken place to prevent their reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and learning from significant events, incidents and accidents. Staff including receptionists and clinical staff were aware of the system for raising significant events and felt encouraged to do so. Significant events and complaints were discussed at the weekly clinical meeting. The practice was aware that they needed to strengthen the process for reviewing that identified actions from significant events had been completed. However we noted from the significant events we reviewed that identified actions had been completed.

We looked at the records of significant events and saw these had been completed in a comprehensive and timely manner and saw evidence of action taken as a result. One significant event related to an error in a high risk medication which had been hand written. GPs we spoke with confirmed the arrangements for prescribing high risk medicines, which did not involve them being hand written. If a prescription was needed for a high risk medicine during a home visit, the GP returned to the practice to print the prescription and if necessary would deliver this back to the patient's home. There was evidence that appropriate learning had taken place and that the findings were disseminated both informally and formally to relevant staff via the weekly clinical meetings and to patients and relatives when they had been involved.

National patient safety alerts were disseminated by email to relevant practice staff and discussed at the weekly clinical meeting. Staff we spoke with confirmed this and were able to give examples of recent alerts that were relevant to the care they were responsible for. Where action was required this was monitored by one of the GPs.

Reliable safety systems and processes including safeguarding

The practice had a range of documentation to advise staff of their role and responsibility in relation to safeguarding children and vulnerable adults. This included safeguarding vulnerable adults and safeguarding children's policies and contact information for safeguarding professionals external to the practice. We saw that information was available on the practice's website and in the waiting room, which explained how to share concerns about vulnerable adults and children with the appropriate agency. We asked members of medical, nursing and administrative staff about their safeguarding knowledge. 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.

The practice had dedicated GP leads in both safeguarding vulnerable adults and children. They had been trained to level three, as had the other GPs at the practice and could demonstrate they had the necessary training to enable them to fulfil this role. Nursing staff had received training to level two. All staff we spoke with were aware who the leads for safeguarding were and who to speak with in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a system to highlight vulnerable patients on the practice's electronic records. The practice sent a letter to follow up patients who had not attended. The practice manager told us that they felt this process could be improved and would start reviewing the process for following up vulnerable patients who did not attend for their appointment. GPs reported that they sent reports to child protection meetings and child in need meetings, as often they were not able to attend.

There was a chaperone policy and patients we spoke with were aware they could request a chaperone. There were notices informing patients that this service was available. 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). Clinical staff who acted as chaperones had had a Disclosure and Barring Service check to help ensure their suitability to work with vulnerable people. Disclosure and Barring Service (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. There were two non-clinical staff who acted as chaperones, albeit infrequently. One of these did not have a DBS and there was no risk assessment in place. We spoke with the practice manager about this and they advised that they had sufficient clinical staff to chaperone, so they would no longer use non-clinical staff for this role, apart from the one who had a DBS. If this situation changed and non-clinical staff were needed, then they would ensure they had a DBS in place before undertaking this role. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Guidance was available to staff which explained what to do in the event of refrigerator temperatures being outside of the accepted range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery.

Processes were in place to check medicines were within their expiry date and suitable for use. Medicines for use in an emergency in the practice and in doctor's bags were monitored for expiry and checked regularly for their availability. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Medicines were stored in rooms that were locked. However we noted during our inspection that one of these rooms had been left open and was unattended.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance and local protocols. Appropriate action was taken based on the results. GPs referred to specialist services for advice when necessary. When patients' medicines were due to be reviewed this was flagged on their computer record and a review was undertaken. This also identified patients who had not ordered sufficient medication, so that their treatment could be reviewed. Patients we spoke with confirmed that their medicines were reviewed regularly. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were not handled in accordance with national guidance. We were told they were collected in at the end of every day, however they were not kept securely during the day.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with and received comments from told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice used an external cleaning company. We saw there were cleaning schedules in place, but did not see any daily records to confirm that cleaning had been completed. We did see a certificate of a deep clean at the practice, which was dated 7 May 2015. We were told by the practice manager that spot checks of the cleaning were undertaken by the external cleaning company. We did not see documented records of these. The practice manager told us that they completed spot checks of the cleaning, but these were not documented. Some cleaning responsibilities were undertaken by clinical staff, for example cleaning of medicine refrigerators and we saw the records of these.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice to the practice on infection control. An environmental audit which included infection control had been completed on 24 October 2014 and included all clinical rooms.

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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Personal protective equipment including disposable gloves 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 liquid soap, hand gel and paper towel dispensers were available in treatment rooms.

Good

Are services safe?

We asked to see the practice's legionella risk assessment. This was not available at the time of the inspection, but was provided to us after the inspection. Legionella is a term for particular bacteria 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. All portable electrical equipment was routinely tested and this was last undertaken on 16 December 2014. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. This had also been completed on 16 December 2014.

Staffing and recruitment

The practice had a recruitment policy and procedures that set out the standards it followed when recruiting permanent clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice checked that GPs were on the performers list and assumed that they had had a Disclosure and Barring check, however they had not sought assurance that this had been undertaken for a new temporary member of staff. We saw that regular checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body.

The practice manager told us about the arrangements for planning and monitoring the number of staff and skill mix to meet patients' needs. There was an arrangement in place for members of staff groups to cover each other's annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were 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 medicines management, staffing, dealing with emergencies, and equipment. The practice also had a health and safety policy and there was an identified health and safety lead. There was a planned maintenance schedule which included for example, fire checks, legionella checks and gas boiler checks. We saw that any newly identified risks, including risks to patients, significant events, complaints or infection control were discussed at the weekly clinical meetings. During the inspection, we did note that security within the practice could be improved, for example we noted that patient identifiable information was stored in an unlocked and unattended room. We discussed this with the practice manager and one of the GP partners, who agreed that they would review the security issues we raised.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told by the practice manager that all staff had undertaken basic life support training. Records we saw confirmed this had been completed and staff we spoke with confirmed this. Emergency equipment was available including access to oxygen and an automated external defibrillator. This is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Oxygen is widely used in emergency medicine, both in hospital and by emergency medical services or those giving advanced first aid. Having immediate access to functioning emergency oxygen cylinder kit helps people survive medical emergencies such as a heart attack. Staff we spoke with all knew the location of this equipment.

Emergency medicines were available in a secure, lockable area of the practice. However we noted twice during the inspection that the room where these were stored was unlocked and unattended. Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated) and hypoglycaemia (low blood sugar). Staff we spoke with knew of their location. Processes were also in place to check whether emergency medicines were available and within their expiry date and suitable for use. Records confirmed that it was checked monthly. All the emergency 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 might impact on the daily operation of the practice. Risks identified included for example, loss of personnel, loss of the computer system and loss of

Good

Are services safe?

essential clinical supplies. Each risk was rated and mitigating actions recorded to reduce and manage the risk. The document also contained relevant contact details for staff to refer to. This was last reviewed in December 2014. A copy had been emailed to all staff and copies of the business continuity plan were kept off site.

The practice had a fire safety procedure and had carried out a fire risk assessment that included actions required to maintain fire safety. We saw records of regular checks of the fire alarm, fire doors and emergency lighting. We asked for evidence of checks for the fire extinguishers. This was being requested from an external company and was not provided to us following the inspection. Records showed that all staff were up to date with fire training. There were identified members of staff who were fire officers.

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 used guidelines critically and appropriately. They accessed guidelines from the National Institute for Health and Care Excellence (NICE), and from local commissioners, but also from other sources where these were more relevant. For example, in relation to osteoporosis, they used guidelines from the National Osteoporosis Guideline Group (NOGG). These were shared by email and hard copy and were also shared at weekly clinical meetings. The staff we spoke with confirmed that patients 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 national guidelines and best practice and these were reviewed when appropriate.

Each of the GPs at the practice was a clinical lead for one long term condition and had responsibility for updating protocols which related to those areas. The practice had obtained funding from the Evelyn Trust for a long term condition nurse to work specifically with patients aged 16 to 65. A diabetes specialist nurse and dietitan held a clinic at the practice every other week to review patients with complex needs. Virtual case reviews were held four times a year and included the diabetic consultant, diabetes specialist nurse, practice nurse and lead GP for diabetes. Patients told us that they were reviewed regularly for their long term conditions.

The practice had a process in place for referrals to be made and monitored. We saw referral data which showed that the practice performed in line with other practices in the local commissioning group (LCG). However, they were higher than the LCG for emergency admissions. The practice were actively reviewing this and we were told that improvements were being made.

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

The practice had a system in place for completing clinical audit cycles. One audit looked at the prescribing of an oral antibiotic used in the treatment of urinary tract infections for patients who had renal impairment. Data collected between 1 August 2013 to 1 April 2014 showed 245 prescriptions for this medicine had been issued to 154 patients. Of these, 21 had renal impairment. A protocol was written and a trigger pop up box put in place if patients with renal impairment were prescribed this medicine. An email was also sent to the GPs to inform them of the protocol and actions implemented. A repeat cycle was undertaken between 1 August 2014 and 31 December 2014. There had been an increase in the number of prescriptions for this antibiotic. One patient had been prescribed this antibiotic and had renal impairment, however this was clinically appropriate for that patient.

GPs in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and National Institute for Health and Care Excellence (NICE) guidance. We found that GPs who undertook minor surgical procedures were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used that in their learning.

The practice also collected information for the Quality and Outcomes Framework (QOF) and used their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework (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 e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data showed that the practice scored above or the same as the local Clinical Commissioning Group (CCG) and England average in most of the clinical areas. This included for example, dementia, cancer, depression, learning disability, stroke and transient ischemic attack. The practice were aware of their lower than expected prevalence of coronary heart disease and had investigated and concluded that it was mainly due to their younger than average patient profile. They were continuing to prioritise smoking cessation, as the prevalence of smoking was up to ten times higher that of other practices in the Clinical Commissioning Group area.

Good

Are services effective?

(for example, treatment is effective)

We saw evidence that medication reviews of repeat prescriptions were carried out proactively at the end of the prescribing period and were not triggered by a patient request for a repeat prescription. This meant that patients who did not request prescriptions were identified and reassessed. The patients we spoke with confirmed that their medicines were reviewed regularly. This was also confirmed by the representatives from the supported housing services where patients were registered with the practice.

Effective staffing

The practice had an induction checklist which was used for all new staff starting work. This covered a range of areas including introduction to team members, health and safety, confidentiality and security. We were told that new staff underwent a period of induction when they first started to work at the practice. The staff that we spoke with all confirmed that this happened.

The practice staff included medical, nursing, managerial reception and administrative staff. We reviewed the practice's training spread sheet and saw that staff had undertaken training, such as safeguarding, information governance, health and safety, infection control and equality and diversity. The 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.

All GPs were up to date with their annual 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). These checks and records were also kept for regular locum GPs.

The practice had an appraisal process in place for its staff. We spoke with staff who confirmed they had received an annual appraisal, that their development needs had been identified and planned for and they felt supported in this process. We looked at one staff file and found evidence of appraisal documentation including an invitation letter, guidelines on the appraisal process and a copy of the appraisal.

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. There were effective systems in place for dealing promptly with outpatient letters, discharge summaries, out of hours and accident and emergency reports, and lab and scan reports. These were all done by the clinicians electronically on the system so there was an audit trail. This was also the case for routine outpatient referrals, urgent referrals, for example deep vein thrombosis and new chest pain and suspected cancer referrals.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract.) The practice reviewed all unplanned and emergency hospital admissions to see if they could have been prevented and to reduce unnecessary future admissions.

The practice held multidisciplinary team meetings on a bi-monthly basis, with the community matron, district nursing team and other professionals as required, according to the needs of the patients being discussed. These were organised by the multi-disciplinary team coordinator. The practice had regular meetings with the GP lead for safeguarding children and other health professionals, including health visitors to discuss children who were at risk or in need. Decisions about care planning were documented in a shared care record. The practice had a palliative care register and also used the multidisciplinary team meetings to discuss the care and support needs of patients and their families.

Information sharing

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment.

The practice used the Choose and Book system for making referrals, although this is currently being replaced by the new e-referrals system. (Choose and Book is a national

Good

Are services effective?

(for example, treatment is effective)

electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We saw that the practice had a consent protocol. The clinicians we spoke with described the processes to ensure that consent was obtained and documented from patients whenever necessary, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients we spoke with, and received comments from, confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. The clinical staff we spoke with demonstrated an understanding of Gillick competency test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The practice had Mental Capacity Act policy available for staff. The Mental Capacity Act (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The GPs and nurses were knowledgeable about the Mental Capacity Act 2005 and their duties in fulfilling it. They had received training in this area and they understood the key parts of the legislation. They were able to describe how they implemented it in their practice and gave examples of how a patient's best interests were taken into account if a patient did not have mental capacity.

Patients who needed support from nominated carers were identified on their patient record. Where this information was known, clinicians ensured that carers' views were listened to as appropriate. This was supported by the patients we spoke with during the inspection and from the feedback from the representatives of patients who lived in sheltered housing.

Health promotion and prevention

There was a large range of up to date health promotion information available at the practice and on the practice website, with information to promote good physical and mental health and lifestyle choices. The practice website referred patients to a range of information supplied by NHS Choices and nationally recognised organisations. This included information on a number of long term conditions, family health and minor illness. The practice offered a number of health promotion initiatives at the practice. This included smoking cessation, family planning, a 'hearing help' clinic and podiatry. They had a health trainer to help and support patients with lifestyle issues such as losing weight, becoming more active, drinking less alcohol and stopping smoking. Patients at risk of disease were also reviewed, for example patients with impaired glucose tolerance and those with gestational diabetes.

We saw that new patients who registered at the practice were given a health questionnaire to complete. This enabled the health care team at the practice to make an initial assessment of their health. Patients with existing health conditions were invited into the surgery for a more in depth assessment and review of their needs. If the patient was prescribed medicines or if there were any specific health risks identified then they were also reviewed by a GP in a timely manner. NHS health checks were offered to all patients between the ages of 40-74 years. The practice provided data from 2014 to 2015, which showed that 249 patients were eligible for a health check and 183 had received one. This was a 73.5% take up rate.

The practice had numerous ways of identifying patients who needed additional support. They held a register of patients with a learning disability and 50% had received an annual health check in the previous year. However, nationally reported data showed the practice performed above the Clinical Commissioning Group (CCG) and England average for people with a learning disability. The practice sent a letter to vulnerable patients who did not attend for their appointment. The practice manager informed us that this was an area that they would further improve. In house counsellors were available for patients who needed emotional support. Referrals were made to the improving access to psychological therapies (IAPT) service.

We looked at the most recent Quality and Outcomes Framework (QOF) data and noted that the practice had scored higher than the Clinical Commissioning Group (CCG) and England average for cervical screening (100%), child

Good

Are services effective?

(for example, treatment is effective)

health surveillance (100%), primary prevention of cardiovascular disease (100%), contraception (100%) and smoking (95.5%). They scored the same as the CCG and England average for obesity (100%).

Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. The percentage of children receiving vaccination was in line with or slightly below the percentages for the Clinical Commissioning Group. Clinical staff we spoke with told us about the arrangement in place for following up patients who did not attend for their immunisations. They offered immunisation and advice for Hepatitis A and Typhoid and further information about vaccinations that were required for different countries was provided on their website.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a person centred culture at the practice. Staff and management were committed to working in partnership with patients. During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. We spoke with ten patients and reviewed 12 CQC comment cards which had been completed by patients to tell us what they thought about the practice. Patients told us that staff were caring, they were treated with respect and their privacy was maintained.

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 and clinical room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We spent time in the waiting room and observed a number of interactions between the reception staff and patients coming into the practice. The quality of interaction was consistently good, with staff showing genuine empathy and respect for patients, both on the phone and face to face. 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 reception was located separately to the waiting room area. There was a notice asking patients to respect other patients' privacy. Staff we spoke with told us that they would invite patients to a private room if they were upset or if they were sharing sensitive information. However there was no notice informing patients that they could request this.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. 321 surveys had been sent out with 99 being returned, which was a response rate of 31%. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (72%) and for whether nurses listened to them, 73% reported this as being good or very good. Satisfaction rates for patients who thought they were treated with care and concern by their GP was 85% and for whether the GP listened to them, 87% reported this as being good or very good. 86% of respondents described their overall experience of the practice as fairly good or very good and 74% of patients stated they would recommend the practice. These results were average or slightly lower when compared with other practices in the CCG area.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they were involved in decisions about the care and treatment they received. They also told us they felt listened to and supported by staff. Patients reported they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive and did not feel rushed. Patient feedback on the comment cards we received was also positive and aligned with these views. Some of the staff we spoke with gave examples of how they explained options for treatment in a way that patients understood.

Data from the national GP patient survey, published on 8 January 2015, showed 66% of practice respondents said the GP involved them in care decisions, 78% felt the GP was good at explaining tests and treatments and 83% said the GP was good at giving them time. In relation to nurses: 57% said they involved them in care decisions; 70% felt they were good at explaining tests and treatments and 70% said they were good at giving them enough time. These results were slightly below average when compared with other practices in the Clinical Commissioning Group (CCG) area. However we checked the results for these areas from the National GP patient survey which was published on 2 July 2015 and found that these percentages had significantly improved, with the practice scoring in line with or above the CCG average. For example, the responses for nurses was 89% said they involved them in care decisions; 95% felt they were good at explaining tests and treatments and 90% said they were good at giving them enough time.

Patient/carer support to cope emotionally with care and treatment

Information for carers, in the form of leaflets and posters were displayed in the waiting rooms. These provided information on a number of support groups and organisations that could be accessed for patients, relatives

Good

Are services caring?

and carers. Information for carers was also available on the practice's website which included taking a break, housing, benefits and signposted carers to other sources of support. There was also a link on this page for carers to submit information to the practice so they could be identified as carers by the practice. When a new patient registered at the practice they were asked if they were a carer or had a carer and the practice identified them on the computer system. The practice took part in the Carer's Prescription Service. When GPs identified patients in their practice who provided care to others, they could write a prescription for them which could be 'cashed in' by the carer to access a specialist worker at Carers' Trust Cambridgeshire for support, information and respite care.

Staff told us that if families had suffered bereavement, a GP undertook a bereavement visit or consultation. If staff from the local hospice had been involved with the family then they would visit bereaved family members. Patients who had had a miscarriage were also referred to counselling services when appropriate. We were told that patients were referred to local external organisations that provided specialist services, when this was appropriate. Information was available on the practice's website titled 'In times of bereavement.' We noted that unexpected deaths were discussed by clinical staff to identify if there was anything that could be learnt or done differently.

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 needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice were aware of the health inequalities experienced by some of the patient population. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs. For example, the Citizens Advice Bureau service and the long term condition nurse for patients aged 16 to 65 years. This service had been running for approximately three months and positive patients outcomes had been identified. These included a reduction in GP time and hospital admission and verbal feedback from patients had been extremely positive. The practice were also participating in the Clinical Commissioning Group (CCG) asthma care review.

A number of the GPs at the practice were part time. Systems were in place to promote continuity of care for patients. These included GPs 'buddying' for each other and sharing information proactively for patients who were likely to need a follow up appointment. The GPs documented the future plan of care for the patients on the patient's medical record so that this was known to the GP who reviewed the patient. Patients we spoke with commented positively that the GPs were aware of their health needs and treatment plans, even when they saw another GP. The majority of patients we spoke with on the day of our inspection told us they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this.

The practice had a face to face and a virtual patient participation group (PPG). (This is a group of patients registered with a practice who work with the practice to improve services and the quality of care.) The practice manager showed us the analysis of the last patient survey, which was completed in 2013 to 2014. The views of the PPG had been considered in relation to the patient survey. The results and actions agreed from this survey were available on the practice website. We spoke with representatives from the PPG who confirmed that the practice had responded positively to suggestions to improve the practice, for example improving telephone access.

Tackling inequity and promoting equality

The practice had an equality and diversity policy. The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. The GPs we spoke with told us there was a low threshold for patients who did not speak English well and for young children to be given an appointment following assessment by the telephone triage GP. Staff told us that a translation service, Cintra, was available for patients who did not have English as a first language. Longer appointments were available for patients who needed them, including those who needed an interpreter. There was a self check in screen which could be accessed in four different languages. We were told by staff that patients who needed support to complete registration forms were supported to do this and we observed this during the inspection.

The practice was situated in a single level building. There were automatic opening doors at the entrance so patients were able to independently access the practice. The waiting area was large enough to accommodate patients with wheelchairs and prams. There was suitable access for patients with mobility needs, to all the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There was free parking at the practice.

Access to the service

The practice opened every week day from 8:30 am to 6:00pm. We spoke with one of the GP partners who told us that they had previously had longer opening hours to support patients who worked. They advised that this had not been as effective as they had hoped. The GP partner told us that if patients needed to be seen outside of these hours, then an arrangement was made.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange routine appointments, which could be booked by telephone, in person or online. These were usually available with the patient's usual GP. Requests for urgent appointments were managed by a GP led telephone triage system. A GP called

Good

Are services responsive to people's needs?

(for example, to feedback?)

the patient back to discuss the most appropriate care, which might include being given an appointment at the practice, with a GP, nurse practitioner or minor illness nurse. Telephone advice from a GP and home visits were also available. The sheltered housing representatives we spoke with confirmed that requests for home visits were responded to in a timely way. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015 and found that 67% of patients described their experience of making an appointment as fairly or very good, which was below the Clinical Commissioning Group (CCG) average. However 98% said the last appointment they got was convenient, which was above the CCG average. Comments received from patients on the day of the inspection showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. Two patients were dissatisfied with the wait to see a GP for a routine appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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 on the practice website and patient leaflet, to help patients understand the complaints system. Staff we spoke with advised that complaints tended to be dealt with verbally in order that they could be resolved immediately. However, patients could also put their complaint in writing in order that it could be investigated and responded to. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

The practice had received six complaints from March 2014 to March 2015. We looked at two complaints which had been received during this time. These had been acknowledged, investigated and a response had been provided. Complaints had been dealt with in a timely way and an apology had been given where this was appropriate. We noted that the patient information leaflet that was given to patients when the practice responded to their complaint, did not include information about how to escalate a complaint if a patient was not satisfied with the outcome. However, this information was included in the complaints policy. The practice manager agreed they would add this information to the patient information leaflet on complaints.

The practice discussed and reviewed complaints at the weekly clinical meetings in order to identify areas for improvement. The practice had implemented learning from complaints to improve the service offered to patients. For example, the process for managing referrals had been improved. The practice completed an annual review of complaints and we saw the minutes of this meeting.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had aims and objectives in place. These were 'to deliver high quality general practice services, to work in partnership with patients, to recognise the deprivation of the patient population and minimise inequalities, to focus on health promotion and encourage self-care, to work with other professionals, improve healthcare services through learning, monitoring and auditing, to take care of staff, to act with integrity and confidentiality and to treat all patients and staff with dignity, independence, respect and honesty in an accessible, safe and friendly environment.' This was detailed in the statement of purpose for the practice.

We spoke with a number of clinical and non-clinical staff and they all demonstrated these shared values, embraced the principles of providing a patient centred service and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available electronically on the practice's computer system. Staff we spoke with knew where to find these policies if required. We looked at a sample of eight policies and procedures and most had been reviewed and were up to date. However we noted that two policies did not have a date for review on them and one policy was overdue for a review.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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 e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data for this practice showed

it was performing in line with national standards for the majority of areas. The practice achieved a 93.7% score (of total available points) which compared with the local Clinical Commissioning Group average of 89.3%. The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks which they were immediately responsible for. However the process for obtaining assurance for work and checks which were undertaken by an external agency, could not all be evidenced in a timely way. Risks were discussed at the weekly clinical meeting and actions taken as appropriate. The practice had arrangements for identifying, recording and managing significant events and a system for the management of complaints.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a GP lead for learning disability and GP leads for safeguarding. We spoke with a number of clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities.

There were a number of meetings held at the practice in order to share information and provide support for staff. These included weekly clinical meetings, weekly team meetings, which were held on alternate days so more staff were able to attend, and quarterly clinical governance meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings with the practice manager, or the GPs. There was a willingness to improve and learn across all the staff we spoke with. Evening social events were also held for the staff team.

There was clear clinical leadership at the practice. The GPs we spoke had actively considered potential future possibilities for the practice. These included for example, federating, improvements needed to the building, and the potential increase to the patient population. Whilst no decisions had been made about these areas, this showed that the clinical leaders were proactive in ensuring they were in a positive position to respond to any future changes.

Seeking and acting on feedback from patients, public and staff

We found the practice listened and responded in a timely way to formal and informal feedback from patients. Feedback from patients had been obtained through patient surveys, the friends and family test, the patient participation group, a suggestion box and complaints.

The practice collated feedback from patients from the 'friends and family' test, which asked patients, 'Would you recommend this service to friends and family?' The friends

Are services well-led?

Good

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

and family feedback form was in the waiting room for patients to complete and on the practice's website. We were provided with the following data from the practice. In November 2014, 9 cards had been returned with 89% recommending the practice and in December 2014, 11 cards with 82% recommending. 31 cards had been returned in January 2015, with 91% of patients saying they would recommend, for February, five cards were returned with 100% recommending. In March, 20 cards were returned and 90% would recommend. In April, 1 card had been returned with 100% recommending the practice. We were shown an action plan, dated March 2015, which identified that although reception staff had received customer care training, the practice would continue to provide training in this area. Some of the reception staff we spoke with confirmed this had happened and we were also shown certificates of attendance. The practice identified that they would continue to encourage patients to complete the friends and family test cards in order to obtain on-going feedback.

The staff we spoke with described the working environment as caring and supportive and that they felt valued. We were told they felt that any suggestions they had for improving the service were taken seriously and staff told us they were listened to. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in paper copy. Staff we spoke with were aware of the whistleblowing policy or where they would be able to find a copy. Staff felt that they were easily able to raise any concerns and that they would be listened to.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They commented positively on the clinical support they could easily obtain from the GPs and each other. Our review of the clinical meeting minutes confirmed that this happened. Staff confirmed that regular appraisals took place and they found them supportive. All the staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any questions they had. Clinical staff we spoke with confirmed that they were supported to attend external learning and development meetings with their peers. The practice also closed for staff training for half a day on a quarterly basis.

The practice was a GP teaching practice and supported GP Registrars, who were qualified doctors training to be GPs and medical students who were training to become doctors. We spoke with one GP registrar, who told us they were provided with tutorial time with the GP trainer, had training from GPs with special interests and had access to all the GPs for advice and support. When they saw patients, they were initially given extended appointments to enable them sufficient time for the consultation. They told us they felt very well supported and gave positive feedback on the clinical expertise of the GPs. We spoke with one of the GP trainers who told us that they provided mentoring for other, less experienced GP trainers at other practices and they also supported all practices locally, if requested, by offering a mentoring service for inexperienced GP partners. An example of this was at a local practice where a number of partners left in quick succession, leaving a very new and inexperienced GP Principal as the senior partner.

The practice had completed reviews of significant events and other incidents and shared with staff both informally and formally at meetings to ensure the practice improved outcomes for patients. The results of patient surveys were also used to improve the quality of services. Comments received from patients were also discussed at the patient participation group meetings. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care.