West Road Surgery

Quality Report

101 West Road
Shoeburyness
Southend on Sea
Essex
SS3 9DT
Tel: 01702 293535
Website: No website

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

On 06 November 2014 we carried out an announced comprehensive inspection of West Road Surgery, 101 West Road, Shoeburyness, Southend on Sea, Essex under our new approach of inspection of primary medical services.

We found that the practice was good overall in all the areas of safe, effective, caring, responsive and well-led.

Our key findings were as follows:

- Patients and staff were kept safe because processes and procedures were being followed. Safety incidents were thoroughly investigated, analysed and learning opportunities had been identified. Robust infection control procedures were in place.
- The appointment system was effective and patients across the population groups were very satisfied with it. Consultations and assessments were in line with published guidance.
- Patient's privacy and dignity were maintained and staff treated them with dignity, compassion and respect. Feedback from a variety of sources reflected that practice staff were kind and caring.
- The practice responded to the needs of their patients and they were involved in the planning of their care and treatment.
- There was strong visible leadership in place with an ethos of learning and improvement embedded into their procedures. Staff embraced the vision of providing high quality and care and were involved in the future of the practice.
- The monitoring and assessment of the services provided was achieved through a range of clinical and non-clinical audits. These were clear, concise and identified areas for improvement, followed up by timely action.

Professor Steve Field

CBE FRCP FFPH FRCGP

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Systems and processes in place were thorough and robustly monitored. Infection control procedures were being followed and all staff had received appropriate training. Children and vulnerable adults were protected against the risk of abuse. A nominated lead had been identified for safeguarding and staff had received training relevant to their role. There were sufficient numbers of skilled and qualified staff at the practice and they were trained to provide the services offered. There were clear systems to ensure that staff and patients were safe. The practice learned when things went wrong, through analysis and the identification of improvement areas. These were cascaded to staff at team meetings and during the appraisal process.

Are services effective?

Good

The practice is rated as good for effective. Patients received assessments that met published guidance from both the GP and nurse working at the practice. Staff at the practice were all qualified to carry out their roles. They were supported in the workplace through regular appraisals, training was provided and it met the needs of patients. Staff were provided opportunities for learning and development. New staff to the practice went through a robust recruitment procedure, followed by an induction period to familiarise themselves with the systems in place. Patient's conditions were monitored regularly. Audits were in place to check on the effectiveness of treatments and medicines. Care plans were in place for those requiring additional support.

Are services caring?

Good

The practice is rated as good for caring. Feedback from patients was positive about the way they were treated. Patients were treated with dignity, respect and kindness and their privacy was maintained. Chaperones were available for patients to access if required. Patients were involved in their care and treatment planning and explanations to them were clear. The practice understood the needs of their patients. Information was available to patients about the services provided and how to obtain support from external organisations. Emotional support was available to patients to help them manage their conditions after bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing effective services. The practice was aware of the needs of their patient population and planned their services accordingly. The appointment system met

Summary of findings

the needs of the various population groups and emergency appointments were prioritised for children and other vulnerable patients. Telephone consultations and home visits were routinely offered. There was an effective system in place to manage patients' prescriptions including free home delivery by a local pharmacy for those housebound or with limited mobility. The facilities and premises were suitable for patients and there was ready access for people with disabilities. Waiting times, appointments and seasonal demand was monitored regularly and changes made to staffing levels and the number of appointments available at peak times. The complaint procedure was effective with guidance available for patients and clear investigations, analysis and apologies where necessary. Any learning was cascaded to staff.

Are services well-led?

Good

The practice is rated as good for being well-led. There was overt, fair, supportive leadership. The leadership, governance and culture of the practice were used to drive and improve performance. All staff embraced this concept and were involved in providing high quality care and identifying areas for improvement. The staff were supported to be involved in the direction the practice was taking and there was a clear no blame, learning culture amongst all the staff we spoke with. Policies and procedures set out the standards for staff to aspire to and they achieved them. Practice and staff performance was extensively monitored and effective outcomes achieved. A wide range of audit and re-audit took place of both clinical and non-clinical services. These were completed to a high standard with a thorough attention to detail. Learning was a continuous theme throughout the practice and well documented. Staff were clearly aware of all relevant issues and were included in the learning. Staff appraisals were linked to the objectives of the practice and training provided and monitored. Staff were encouraged to submit ideas for improvement either personally, at team meetings or at appraisals. Staff felt supported and made positive comments about the leadership at the practice. This was echoed by senior colleagues about the quality of staff working there. Staff satisfaction levels were high and they were proud to work at the practice. The turnover of staff was very low. Governance and performance were monitored regularly and reviewed. The overall performance of the practice was linked to financial incentives for all staff working there. The achievement rates on their targets for the year ending March 2014 were 99.8%. All policies were up to date and staff were fully aware of these.

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 older people. Older patients at risk were recorded on a register and monitored. Monthly multi-disciplinary and palliative care meetings took place with a range of health care professionals in attendance. All patients over 75 years of age had a named GP who was responsible for the oversight of their care and treatment. Regular health reviews of older patients took place. Older patients who were identified as particularly vulnerable were identified and care plans put in place to reduce the risk of unplanned hospital admissions. Appointments were prioritised for older people and home visits available if they were too ill to attend or were housebound. Information was provided to them about dietary advice, financial benefits and health guidance. Prescriptions were delivered by a local chemist to their homes. Flu vaccinations were readily available and the nurse attended patients' homes for this purpose if they were housebound or less mobile. Patients who were vulnerable were signposted to external support such as Age Concern.

People with long term conditions

Good

The practice is rated as good for patients with long-term conditions. Patients with long-term conditions were included in a register so their health could be regularly monitored. Care plans were put in place for them and steps taken to avoid unplanned hospital admissions. Health reviews were undertaken as required but at least annually or six monthly. Those discharged from hospital were contacted within three days to review their condition and their care requirements. A monthly meeting took place with the community matron to discuss individual patients care and support needs Same day appointments were available for urgent issues and telephone consultations and home visits were available. A pro-active system was in place to identify those eligible for flu vaccinations. Nurses attended people's homes if they were too ill to attend the practice. Long term conditions were regularly monitored by the nurse and appropriate advice and guidance given.

Families, children and young people

Good

The practice is rated as good for families, children and young people. A child protection register was being used at the practice and those at risk monitored for signs of abuse. All relevant staff had received child protection training. Quarterly meetings took place attended by representatives from the practice and health visitors, where individual cases were discussed and care and treatment

Summary of findings

planned accordingly. The practice was pro-active in identifying those patients due for cervical smear testing. Eligible patients were written to advising them it was due. Chlamydia screening was routinely offered for those between the ages of 16 and 24 and contraception advice was available. Childhood immunisation programmes were in place and monitored for compliance with national targets. All staff were aware of Gillick competence so children aged 16 and under could obtain an appointment with the GP or Nurse without an adult being present.

Working age people (including those recently retired and students)

Good

Evening appointments were available on one evening each week for those patients unable to access the practice during working hours. Appointments could be booked or cancelled on-line and a question facility was available on-line for patients to post questions about clinical matters. Repeat prescriptions were also available on-line after registering for this service. The practice offered health check for patients who were otherwise healthy, to establish whether there were any medical issues apparent, such as raised cholesterol levels or hypertension. Lifestyle advice was also available for smoking cessation, alcohol or weight loss.

People whose circumstances may make them vulnerable

Good

Annual reviews took place for patients with learning disabilities and a register was in place to ensure they were monitored effectively. Double appointment times ensured that all issues were covered that affected their health. Care plans were discussed with patients and their carers. Patients who were vulnerable were signposted to a safeguarding advice line which was a service offered by a local partnership project. Patients who lived in vulnerable circumstances could register at the practice and were offered a health check with the practice nurse. Issues identified were referred to the GP for a follow-up consultation.

People experiencing poor mental health (including people with dementia)

Good

A counselling service was available for patients experiencing poor mental health, provided by the Clinical Commissioning Group, who attended the practice each week. There were leaflets and a dementia handbook for patients and their relatives to understand their condition and to enable them to receive support. A dementia nurse was available for patients to be referred to who worked in the community. Before medicines were changed for a patient, the impact on their mental health was considered in all cases to ensure it was in their best interests and did not cause them distress. Patients were signposted to services where they could obtain

support, including a health crisis telephone line. Appointments were prioritised if matters became urgent and telephone consultations were available. Patients with mental health issues were monitored using care plans to try and avoid unplanned hospital admissions and annual health reviews took place. There was a system in place to contact patients who did not attend for their appointment to ensure they remained fit and healthy. The GP at the practice had access to a mental health crisis line that supported patients needing urgent support.

Summary of findings

What people who use the service say

On the day of the inspection, we spoke with several patients waiting to see their GP or nurse. They told us that they were very satisfied with the practice and found staff to be kind and caring. They said they thought the practice was always clean and tidy and that staff were well trained. They were complimentary about the services provided by both the GP and the nurse working there.

Most people spoken with were very satisfied with the appointment system but some had found it difficult on occasions to get an appointment that suited them. Patients told us that there were no problems experienced in getting an urgent appointment when they needed one and if necessary they received a telephone consultation to offer advice and guidance. We were told that the system for obtaining repeat prescriptions was effective and the immunisation programme for children was organised and efficient.

Prior to visiting the practice we left comment cards for patients to complete, describing their experience of the practice. We reviewed the 16 cards that were left for us. Patients were very complimentary about all the staff working at the practice and the way services were provided. They said that their dignity and privacy was respected, they felt listened to and that staff were friendly and helpful. Many described the practice as excellent and were very satisfied with the appointments system and the explanations given about their care and treatment options.

The results of a practice patient survey carried out in 2014 demonstrated that patients were very satisfied with the services provided at the practice. Where improvements had been identified, these were put into an action plan and developed to improve the services provided.

West Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector accompanied by a specialist GP advisor.

Background to West Road Surgery

West Road Surgery is situated in Southend on Sea, Essex and is one of 36 GP practices in the Southend Clinical Commissioning Group (CCG) area. The practice has a General Medical Services (GMS) contract with NHS England.

Although the practice does not have on-site parking facilities, patients are able to park nearby in surrounding streets. The building is suitable for patients with wheelchairs or with limited mobility. An accessible toilet available as is a mother and baby changing area.

There are approximately 2700 patients registered at the practice.

There is one full time male GP working at the practice and two female nurses. There is also a full time practice manager, an assistant practice manager and a number of reception and administration staff. A branch surgery is located at Watkins Way Surgery, Shoeburyness, Essex. We did not visit this location as part of our inspection.

GP sessions run each day in the morning and afternoon and on Thursday's surgery hours are extended until 7.45pm. The nurse works full time and has daily sessions.

The practice has opted out of providing out-of-hours services to their own patients so patients contact the emergency 111 service to obtain medical advice outside of normal surgery hours.

Why we carried out this inspection

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

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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 November 2014.

During our visit we spoke with the GP, nurse, practice manager and reception and administration staff. We also spoke a number of patients who used the service and observed the inter-action between staff and patients. We looked at policies, documents and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. An effective system was in place to handle national patient safety alerts, significant events, complaints and safeguarding adults and children. We followed through their processes form receipt of the information to action being taken and found them to be robust.

We found that across the practice, record keeping was of a high standard with clear analysis, findings and improvements identified and actioned.

Staff we spoke with were aware of the designated leads for each area and knew the reporting procedures and followed them. They told us they were encouraged to report any incident and that their concerns were taken seriously. The practice had a 'no blame' culture and embraced the ethos of reporting safety concerns and learning from them.

Staff were aware of external organisations they could report incidents to if required and the practice had details of these organisations for all staff to refer to if they so wished.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff were aware of the requirement to report incidents, however minor and knew the procedures.

We viewed the records held for several significant events. They were very detailed containing information about the concern, the impact on the patient, a detailed analysis and any action for improvement. Once the investigation had been completed, the proposed action was referred to a senior member of staff for quality control purposes. Once approved, this was then cascaded to staff for learning purposes which was also documented in the minutes of team meetings and on the serious event records. This was a standing item on the team meeting agenda.

All staff spoken with were aware of the procedures to follow and confirmed that staff meetings were used to learn from incidents.

National patient safety alerts were dealt with in an effective manner. On receipt of the information it was cascaded to relevant staff by email and through internal memorandums. Where necessary individual patient records were marked accordingly. The responsibility for assessing the information and any action required was clearly defined and was the role of the GP. Where patients needed to attend the practice to conduct a review of their care and treatment, an effective system was in place to notify them and offer them an appointment.

Complaints were also managed effectively. Record keeping was of a high quality and included the details of the investigation and the identification of any safety issues. Patients were included in the learning process where applicable and staff informed in a timely fashion to reduce the risk of reoccurrence.

Reliable safety systems and processes including safeguarding

The practice had a designated lead for safeguarding vulnerable adults and children who was appropriately trained. Those patients identified as at risk were placed on a register and regularly monitored. Regular multi-agency meetings took place, attended by the GP lead, for the on-going management and support of patients at risk.

Vulnerable patients were highlighted on the computerised record system and this alerted the GPs and staff, when a patient on the risk register attended for an appointment. This enabled them to be monitored to ensure they were safe and referred to support agencies when required.

All staff had been trained in safeguarding and were aware of the different signs of abuse. There was a system in place for staff to report any concerns to the designated lead for safeguarding or other senior member of staff. Staff we spoke with had a sound knowledge of safeguarding procedures and knew the action to take if they felt that a patient might be at risk. The local authority procedures were readily accessible to all staff and a list of useful contacts and telephone numbers, to seek advice, could be accessed.

A chaperone policy was in place that described the procedures to follow. The practice nurse had received formal chaperone training and this was cascaded to non-clinical staff so they could deputise in the absence of the nurse. Staff we spoke with were aware of the requirements of the role and where to stand when an examination was taking place. However one member of staff was unsure of the procedure to follow when acting as

a chaperone. At our inspection the practice manager agreed to undertake some follow-up training to ensure all staff understand the procedures to follow. A sign was available in reception to inform patients that this service was available to them.

A system was in place to monitor patients with poor mental health who did not attend for appointments. Follow-up telephone calls were made to encourage patients to attend, and if there were concerns this was escalated to the community nurse to check on the welfare of a patient.

The practice had a whistle blowing policy and staff we spoke with were aware of the procedures to follow and who they could contact externally if they needed to. They told us that they felt that the managers at the practice would listen to any concerns they raised and deal with them effectively.

Medicines management

We checked the medicines in use at the practice and found that they had been stored correctly and in line with published guidance. The practice worked in partnership with the local Clinical Commissioning Group to undertake medicines audits and monitor their prescribing patterns. This ensured they were providing value for money and using the best available products for their patients. The audits had helped to identify the over-use of certain types of medicines so that action could be taken.

Fridges used for storing vaccinations and other medicines were in a secure location and accessible to relevant staff only. The temperatures of the fridges were monitored to ensure that medicines were stored at the correct temperatures to maintain their effectiveness. A temperature record log was being maintained on a daily basis. The practice had a procedure which covered the steps to take to ensure medicines were placed in fridges as soon as possible after receiving them. Staff were aware of the procedures to follow.

Stocks of medicines were checked and rotated regularly to ensure they were not stored beyond their expiry date. We checked these medicines and found that they were all in date. Expired medicines were disposed of in line with current guidance.

The GP at the practice had a home visit bag that contained appropriate emergency medicines. These were all in date and a system was in place to ensure they were checked regularly. Records were being maintained that reflected that this was being undertaken.

Nursing staff responsible for administering vaccines could demonstrate that they were appropriately qualified and experienced to deliver them.

All prescriptions were reviewed by a GP before signing them. Blank prescription forms were securely stored and handled in line with published guidance.

Cleanliness and infection control

The practice had an infection control lead that was responsible for overseeing the procedures in place at the practice to reduce the risk of a health care related infection. This was the practice nurse.

We found that robust procedures were in place including cleaning checklists for clinical and non-clinical areas. An infection control audit had been undertaken in 2014 and where improvement areas had been identified, these were clearly recorded. An action plan was in place that identified the improvements required, the timescale for completion and the date when actioned. These were discussed at staff meetings where applicable.

We viewed the checklists held to record the cleaning and the monitoring of the practice and found them to have been maintained to a high standard. We found the practice to be clean and tidy in all areas. Patients we spoke with were satisfied that the practice was clean and hygienic.

All staff were protected against hepatitis B and had received their vaccinations. A system was in place so that staff could receive regular blood tests to check that their immunisation status remained effective. Records were kept and we found that this was monitored effectively.

Hand washing techniques were clearly displayed throughout the practice and there was an adequate supply of liquid soaps, hand towels and alcohol hand gels. Staff we spoke with were aware of the techniques to use and followed them.

An initiative had been implemented to check on the usage of appropriate hand hygiene by patients and staff to reduce the risk of spreading a health care related infection. This involved observing both patients and staff for a period of

time, to see whether hygiene standards and advice were being followed. This included hand washing techniques, the use of hand gel sanitisers and whether surgical gloves were being worn routinely.

The findings of the first observation revealed that 100% of the staff were following guidelines but that patient use of hand gel sanitisers, available to them in the reception area, was minimal. This initiative was in its early stages but there were plans to develop this into a patient education exercise using staff to remind patients about the benefits of the hand gels to reduce the risk of picking up a health care related infection at the practice.

Legionella testing took place annually and was in date. Legionella is a bacteria that can be found in the environment that can contaminate water systems in buildings. This test was undertaken by an external company and records had been maintained.

The practice handled clinical waste in line with guidance. It was stored and labelled correctly. An externally appointed company attended regularly to collect and dispose of clinical waste

Equipment

Staff we spoke with told us that there were sufficient quantities of equipment to meet the needs of patients. These included an electro cardiogram for heart rhythm monitoring, blood pressure monitors, blood/sugar testing machines for diabetic patients, thermometers and weighing scales.

A system was in place for these to be regularly tested and calibrated. Records we viewed reflected that the equipment in use was in working order and easy to use. Where repairs were necessary these had been actioned.

Electrical equipment was the subject of portable appliance testing (PAT) to ensure it was safe and working correctly.

Staffing and recruitment

The practice had a recruitment policy in place that had been reviewed in October 2014. It described the system in place from identifying a vacancy, to a job description through to advertising, interview and selection. It highlighted the need to check experience and qualifications, registration with professional bodies and to confirm identity. This applied to both clinical and non-clinical staff.

The policy would benefit from identifying the roles that require a Disclosure and Barring Service (DBS) check and whether a risk assessment is required if a decision is taken that one is not required. A DBS check replaced the Criminal Record Bureau check and now includes information from the Independent Safeguarding Authority to ensure people are vetted to enable them to work with vulnerable groups. The practice has agreed to review their policy.

All staff were required to go through an induction programme when they first started to work at the practice. This helped them understand how the practice ran, made them aware of the processes in place and explained health and safety procedures.

There were sufficient numbers of staff on duty at all times and there was a mix of skills and experience that met the needs of patients. The practice rarely made use of locums but when they were required we saw that these were planned well in advance of any anticipated GP absences. Staff shortages were considered in advance and suitable cover arranged. Staff generally covered for each other during times of annual leave, training or sickness. The practice manager and assistant practice manager made themselves available to cover reception and administration duties if required.

Monitoring safety and responding to risk

Staff at the practice were aware of the changes to risk or possible deterioration in patient's conditions. Where those patients who suffered from poor mental health did not attend for regular treatment, the practice had a system in place to contact them to check on their condition and to ensure that relevant medicines were being taken. They were encouraged to re-book an appointment as soon as possible and in the event of being unable to contact them, other steps were taken such as requesting a home visit by the community matron.

The practice also monitored vulnerable patients who had been discharged from hospital or who had attended the Accident and Emergency department of the local hospital. The circumstances were reviewed and the patient spoken with, to ensure that a care plan was put in place that reduced the risk of further unplanned hospital admissions. This included elderly patients, those with long-term conditions and patients with poor mental health as well as other vulnerable patients.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice was able to demonstrate that they could deal with emergencies and major incidents.

All staff had received first aid training and the frequency of this was monitored to ensure staff received refresher training. Training certificates were viewed by us on the day of the inspection and a training matrix was in place to identify each staff member and the training they had received.

Emergency medicines were readily available to staff, who knew how to access them. We found there to be sufficient quantities of the correct medicines and equipment and they were stored securely. A system was in place to monitor expiry dates. We found that the emergency medicines would benefit from being more efficiently packaged to ensure easy access if an emergency occurred. The practice had agreed to action this. Oxygen was available, in date and securely stored.

The practice had a business continuity plan in place that was available to staff in both written and electronic format. This document detailed the steps to take if there was an emergency that affected the provision of services and daily operation of the practice. It covered such eventualities as failure of the electricity supply, an illness pandemic, severe weather conditions and how to obtain alternative accommodation. Staff we spoke with were aware of its content and how to access it.

The practice had a fire safety policy. Staff had been trained to manage fire evacuation procedures and were aware of the procedures to follow in the event of a fire. This had been extended to the practical use of a fire extinguisher where staff had the opportunity to practice the using one in a controlled situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with GPs and nursing staff on the day of our inspection and were satisfied that care and treatment was being delivered in line with best practice and legislation. There were systems in place to ensure that all clinical staff were up to date with the latest guidance provided by the National Institute for Health and Care Excellence (NICE) and how to access those guidelines. Patient records were updated and this ensured they received effective consultations and treatment.

The nurses working at the practice specialised in specific chronic disease management that included diabetes, chronic obstructive pulmonary disorder and asthma. They regularly assessed patients during appointments to help them manage their conditions and to offer advice and support. They also carried out annual health reviews of patients with learning disabilities and with poor mental health. Any issues were fully recorded and where clinical matters were apparent, patients were allocated follow-up appointments with the GP for further assessment.

Patients eligible for flu vaccinations were identified and encouraged to attend the practice to receive them. The practice monitored their performance in this area and were exceeding their targets.

There was an effective system in place for the effective management of patients requiring cervical smear tests. Patients were written to and invited to book an appointment. If there were any abnormal results, patients were given a follow-up appointment with the GP. For those patients who did not call the practice about their results, a system was in place to contact them if the results indicated that this was necessary. The practice monitored their performance in this area and were exceeding their targets set by national guidelines.

Patients with complex needs were provided with rescue packs of medicines in the event of an emergency illness. This applied to the elderly, those with long term conditions and vulnerable patients.

Patients were referred to specialists and other services in a timely manner and where urgent, often on the same day. A system was in place to refer patients through the 'choose and book' system.

Patients with long term conditions and those approaching the end of their lives through illness had their needs assessed and were provided with effective care and treatment. Regular multidisciplinary meetings took place and the minutes of those meeting clearly described the ongoing assessment of each patient. Support from external organisations was signposted to them and their families.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included prescribing, infection control, osteoporosis, diabetes management and hospital admissions. The GP at the practice had a special interest in joint injections and was in the process of auditing their effectiveness. Learning from this has highlighted the need to consider how consent was recorded for patients receiving them and at the time of our inspection this was being progressed.

A range of other audits were taking place at the practice that were designed to monitor and improve outcomes for patients. These included health and safety, the appointment system and patient waiting times. Where areas for improvement had been identified, these were recorded and actioned.

The practice had recently agreed to provide an enhanced service to patients in relation to avoiding unnecessary hospital admissions. This involved establishing those patients who were most at risk either through age, a long-term condition or other vulnerable group. A monthly audit had taken place that reflected the number of patients who had attended the hospital as an emergency, and the reasons why. This then led to identifying patients who were in need of regular support that would benefit from additional monitoring to put a care plan in place to avoid a reoccurrence. A register was in existence for this purpose. The Clinical Commissioning Group (CCG) had set the practice an achievement target for this service and they had exceeded it.

The practice monitored its performance through the Quality Outcomes Framework (QOF). This is a performance tool that can be used to support a practice to monitor its effectiveness in relation to key areas of healthcare. This was monitored monthly to ensure they were achieving their

Good

Are services effective?

(for example, treatment is effective)

targets and date we viewed reflected they were on course to achieve a high standard of achievement. For the year ending March 2014 they had achieved 99.8% which was excellent.

Effective staffing

Practice staff included medical, nursing managerial, reception and administration staff. Clear records were kept of staff training requirements and whether staff were up to date with it. This was regularly monitored by the practice manager on a training matrix which identified the type of training required, the frequency and when it was due. Records were kept of staff qualifications and certificates to show that courses had been attended. Protected learning time was available for staff each month and this was used to good effect to discuss issues and provide support to staff. This training had ensured that staff were able to meet the needs of patients.

The GP at the practice had received an appraisal and 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.

The nurses working at the practice had the necessary skills, qualifications and experience to carry out their role. They were given time to undertake their continuous professional development over a five year period, to enable them to keep up to date with their skill levels.

Nurses had received appropriate specialist training in delivering the services provided. These included managing patients with long term conditions such as asthma or diabetes, providing immunisations for children and adults, cervical smear testing and smoking cessation advice.

Staff we spoke with told us they had an opportunity to discuss their training needs either at informal meetings or at their annual appraisal. A training needs form was used for this purpose. We were told that staff were encouraged to develop themselves and that training requests were supported whenever it met with the needs of patients.

We looked at the appraisals for the staff working at the practice and found that they were meaningful and supported them. It was clear that development opportunities and training were discussed and staff were graded on their competency levels achieved throughout the year.

Staff we spoke with told us that it was a two way appraisal process with them being encouraged to contribute to their own performance and learning. The appraisal was clearly linked to their job description and to the objectives of the practice. Staff felt valued, were supported and enjoyed working at the practice

We did find however that some staff members did not wish to have an appraisal as they were content in their role, so they did not receive one. Whilst we accept this may be the wish of an individual, it is important that all staff have their competency measured to ensure standards are being maintained. We spoke with the practice about this on the day of our inspection. We have asked them to ensure all staff receive an appraisal so that their line manager has the opportunity to comment on the quality of their work to identify any training or performance issues. They have agreed to do this in the future.

Working with colleagues and other services

The practice managed blood test results and patients were advised when to contact the practice to obtain them. Any adverse results that had been received were monitored to ensure patients were made aware of them. If they had not called the practice they were contacted directly and advised to attend to see the GP for a follow-up consultation.

Information from other health care providers such as discharge letters or emails, were assessed by the GP and placed on the patient's record. Where action was required patients were contacted and care and treatment provided.

We found that the practice worked together with other services in the management of patients with palliative care needs, nearing the end of their lives. Multidisciplinary meetings took place regularly where individual patients were reviewed to ensure their care plan best met their needs. We read the comprehensive minutes of these meetings which showed they had been attended by the GPs, the assistant practice manager, nurses, palliative health care team and a health visitor. The minutes reflected that individualised care was planned and had been provided.

Good

Are services effective?

(for example, treatment is effective)

Quarterly health visitor meetings had been recently implemented. The minutes of these meetings demonstrated that the ongoing care needs of children under the age of 4 years and who were on the Child Protection Register, had been discussed.

The practice worked with other health care providers to deliver high quality care and treatment to patients. Partnership working was evident across the patient population including Macmillan nurses, community matrons and care workers.

Information sharing

The computerised patient record system was used to record all relevant details about patients on their records. This ensured all staff at the practice had timely information about a person's care and treatment. We found that the GP at the practice was able to update patient records after consultations and without generating a backlog.

The patient record system was used effectively and all staff had access to it. It was used for performance monitoring across all key health performance areas as well as providing staff with tasks to complete to ensure patient's needs had been actioned.

We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. Hospital discharge letters were brought to the attention of one of the GPs for review, action taken if necessary and the patient's record updated in a timely manner.

Information from Accident and Emergency attendance by patients and 'out of hours' consultations, were sent to the practice the following morning and actioned the same day. This was then reviewed, follow-up action taken if necessary and the details added to the patient record.

A 'choose and book' system was in use that enabled patients, referred for specialist treatment, to select their preferred hospital.

The practice used a computerised patient record system known as 'SystmOne' and staff made effective use of it. Consultations, test results and out-patient outcomes were saved into the system so all staff could access the latest information about a patient to enable them to meet their needs.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children Acts of 1989 and 2004. They were able to describe the action to take if they felt that a person did not have the mental capacity to make a decision and also how to support them or a carer or relative. A consent policy was available for staff to refer to which was fit for purpose and recently reviewed.

All staff were aware of Gillick competence. This guidance helps clinicians to identify children aged 16 or under who have the legal capacity to consent to medical examination and care and treatment without a parent or guardian being present. The patients computerised system supported the GP in this regard as a template was available that prompted the GP to consider the capacity of a young child and the questions to ask them so they could be satisfied they understood the implications of any care and treatment.

Patients with a learning disability or suffering from dementia were recorded on a register and monitored regularly. This included consent issues where care plans were used to decide the most suitable care and treatment that was in their best interests. Relevant decisions had been made in line with guidance and carers or relatives views considered.

Patients with palliative care needs were supported about their wishes in relation to resuscitation if approaching the end of their lives. The GP discussed each case individually with the patient, involved relatives where agreed by the patient and recorded any consent in writing.

Health promotion and prevention

New patients to the practice were given an information pack to complete to provide information about their history and medical conditions. They then received an appointment with a nurse to assess their health. If an issue was identified, the patient would be referred to a GP for a follow-up appointment.

The practice offered NHS health checks to all its patients aged 40-75 and their performance in this regard was monitored to ensure they were achieving targets. They were seen by the nurse and if any issues were identified they were referred to the GP for a follow-up appointment.

Patients were able to receive health promotion information. The practice nurse provided advice on smoking cessation and diet to encourage patients to live a

Good

Are services effective?

(for example, treatment is effective)

healthy lifestyle. A range of literature was available for patients in the reception area. Patients eligible for flu vaccinations were reminded of their availability through posters displayed on notice boards in addition to being contacted directly to advise them that they were due. This also included infant immunisations as part of the national programme for young children.

The practice kept a register of all patients with a learning disability and patients were contacted and offered an annual health check. The practice was achieving the targets set for them in this area. Cervical smear tests were also monitored to relevant patients and they were contacted and encouraged to attend when they were due. Where patients had not called to establish the result of the test, they were contacted by the practice. Where concerns were apparent as a result of a test, patients were contacted and invited to attend for a follow-up appointment.

The practice had a programme of cervical screening for their patients. The nurses at the practice contacted patients who were eligible and followed up test results and where relevant follow-up appointments were made with the GP.

The practice also offered a range of immunisation vaccinations for children as part of a national programme of inoculations. The practice was monitoring their performance in this clinical area and were achieving their targets. Travel vaccinations were also available.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff working at the practice treated patients with dignity and respect and we saw this when observing the interaction with staff and patients on the day of our inspection. Staff told us that if a patient wished to discuss something in private, they would be taken away from the reception area and to a side office so the matter could be discussed. Patients we spoke with told us that staff were kind and caring and treated them with respect and maintained their privacy.

Staff we spoke with were aware of confidentiality issues in relation to discussing patient's conditions and maintaining their records, both in person and when on the telephone. Staff were careful to identify the patient before passing on any confidential information such as test results or other medical information.

We observed that consultation rooms were shut when carrying out assessments with patients and we could not hear conversations taking place from outside of the room.

Patients could request a chaperone at their consultation and signs were available offering this facility. Consultation rooms had privacy curtains so that privacy could be maintained during physical or intimate examinations. As there was only one GP working at the practice who was male, patients had no choice of GP, either male or female, but could make use of the chaperone facility.

Patients had completed comment cards and they reflected that they were very satisfied with the way their privacy and dignity was respected. The patient survey also reflected the same findings.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that they had been involved in the planning of their care and treatment. They told us they felt listened to and were not rushed. They said that the explanations they received from the GP and the nurse were clear and they were given time to make a decision about their care and treatment options.

The results of the practice survey reflected that patients were very satisfied with the consultations and the information they received form the GPs and nurse. The CQC comment cards that were completed also reflected high levels of satisfaction amongst patients for being involved in the decisions around their care and treatment.

Due to the nature of the practice population, there had not been the need to call on the services of an interpreter to support patients who did not have English as a first language. However staff were aware of the potential for such a need and had access to an interpreter service if required. The GP at the practice also spoke seven different languages.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with told us that all staff at the practice were compassionate and offered support when they needed it.

The practice took positive steps to identify those in need of extra support from carers or those who were carers themselves. Carers were offered a health check to help ensure that their needs were being met and they were also signposted to other services that could provide additional support such as financial benefits or where to obtain mobility aids.

The reception area contained useful information to support those with caring responsibilities. Literature available included Age concern, Age UK and a carer's advice leaflet. Other information included dietary and dementia advice.

Where bereavement had occurred, relatives and/or carers were contacted by the practice and offered support and information to help them cope emotionally. This included bereavement counselling where required.

Literature in the form of leaflets and posters were displayed in the waiting room area signposting a number of support groups and organisations that could be accessed for patients, relatives and carers. These included information about support for those suffering from long term conditions such as cancer and diabetes and advice for carers in relation to equipment and benefit payments.

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 patient's needs and had systems in place to maintain the level of services provided. The practice understood the needs of the patients and they were tailored to their needs to ensure flexibility, choice and continuity of care. Performance was then monitored to ensure that they provided high quality care and treatment.

The practice demonstrated that they considered the needs of different people in vulnerable circumstances. Although the practice monitored their use of medicines to obtain best value for their patients both in terms of cost and effectiveness, they were aware that changes of medication affected those with poor mental health. Prior to making any decisions about changing a patient's medication, they also considered the impact this had on those who were vulnerable. Each patient was therefore treated individually and where the change of medication may have had some financial benefits, if these were outweighed by the needs of the patient then the medicine was not changed.

All patients at the practice received continuity of care because there was only one GP at the practice. Patients we spoke with told us that they found this reassuring. Chaperones were available for patients who wished to make use of them when undergoing examinations and a sign was available in reception indicating that this service was available.

Home visits were available for older people, those with long term conditions and those with limited mobility. Time was also set aside each day for telephone consultations if they were considered necessary.

Although patient appointments were generally of 10 minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or dealing with multiple issues.

Patients with long term conditions received reviews of their condition either every six or 12 months and more frequently if necessary. This formed part of their performance monitoring to ensure they were being carried out. Data we viewed reflected that they were achieving the targets for these reviews.

The practice had identified those patients who were at risk of their condition deteriorating and offered them additional support to avoid unplanned admissions to hospital. This included older people and those with long term conditions. They were reviewed regularly and provided with appropriate care and treatment to reduce the risk of being admitted to hospital. Care plans were put in place for this purpose. All patients recently admitted to hospital received a telephone call within three days of their discharge and their needs were reviewed.

Patients with long term conditions such as diabetes and chronic obstructive pulmonary disorder (COPD) were able to attend appointments with the nurse to help them manage their conditions. They received information and guidance and their health was reviewed.

Patients we spoke with told us that they were satisfied with the appointment system. They never felt rushed by the GP or the nurse and commented that they were listened to and their needs were understood. Patients told us that they rarely had to wait until the next day to obtain an appointment and if it was urgent they could usually get to see the GP or nurse on the same day.

The nurse at the practice provided antenatal and postnatal care for mothers and babies. The national childhood immunisation programme had been implemented and performance in this area was being monitored and targets achieved. Patients who did not attend were followed up to ensure they received their immunisation. An effective system was in place to contact patients who were due for their cervical screening test. A letter was sent to patients who were eligible and followed up if they did not attend.

Chlamydia screening was available for patients between the ages of 16 and 24 and advice on contraception was available.

The nurse also provided consultations to patients who had less complex health care needs and was qualified to do so. This allowed the GP to concentrate on the more complex issues. Patients we spoke with told us they were satisfied with this service and received appropriate care and treatment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

A service was provided for patients with poor mental health. Patients were given same day appointments where required and in-house counselling was provided. Patients could be referred to 'Therapy for You' a local support agency for people with poor mental health. Literature was available for patients to read and understand their condition and a dementia handbook was also given to those patients who would benefit from it. The GP had ready access to a mental health crisis line so that patients could be referred for specialist support if there was an urgent need.

Working age and student patients were able to book appointments at an evening surgery if they could not attend the practice in work/college hours.

Older people could request repeat prescriptions by telephone if they found it difficult to get to the practice. An arrangement was in place with several local chemists who would deliver prescriptions direct to their homes. These included medication in blister pack form to make it easier for patients to use.

Patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 48 hours but patients we spoke with told us that they were often ready for collection earlier.

The practice did not have a Patient Participation Group but were planning on starting one in the near future. They had tried to encourage patients to join and had held an open day but too few patients had attended.

Tackling inequity and promoting equality

The practice was available for patients to register with regardless of their personal circumstances or vulnerability. This included the homeless, members of the travelling community, persons living with mental health, those with learning disabilities and any other vulnerable group. Registers were held at the practice so that appropriate support could be provided and monitored. Patients from different cultures, religions and beliefs were welcome to register at the practice. A registration pack was available for them and they would be offered a health check with the nurse.

Although the majority of patients at the practice were English speaking, if translation services were required, staff were able to contact an interpreter service if they needed it. The GP also spoke 7 languages.

The premises and services available met the needs of people with disabilities. There was plenty of space for wheelchair users, all consultation rooms were accessible and suitable toilet facilities were available.

Access to the service

Patients we spoke with, feedback left for us on CQC comment cards and the results of patient surveys reflected that patients were generally very satisfied with the appointment system and that it met their needs. We found that the practice regularly reviewed the demand for appointments and made seasonal adjustments to the number available at peak periods and also increased staff numbers to take telephone calls during these times.

Appointments with the GP and nurse were available in the morning and afternoons on each day of the week including a Thursday late evening until 7.45pm. This helped those patients who were working during the day or could not attend during working hours for some other reason.

Times had been allocated each day to provide telephone consultations for patients requiring advice or a consultation. The GP also made home visits to patients who were too ill to attend the surgery or who were housebound had limited mobility.

Patients with long term conditions were reviewed by the nurses working at the practice as part of the general appointment system rather than through weekly clinics. Appointments were available at a time that suited patients and we found that access to the nursing staff met the needs of patients.

The practice had identified those patients who had long term conditions or unable to attend the practice through disability or other means. Nurses made home visits in order to provide them with care and support in relation to their conditions without the need for them to have to attend the surgery.

Patients with learning difficulties or those with poor mental health were reviewed annually and given double appointment times to ensure that all health issues could be covered without them feeling rushed.

Routine appointments with GPs and nursing staff could generally be obtained within 72 hours. Patients with an emergency or with children who were ill would be seen the same day and prioritised. The practice was open late one evening each week so that working patients or those

Good

Are services responsive to people's needs?

(for example, to feedback?)

unable to attend during the day, could access a GP or nurse. Should it be required, patients were advised to attend a local walk-in centre if they were unable to get the appointment time of their choice.

Appointments for patients eligible for flu vaccinations could be obtained throughout the week. These included the older people, those with long term conditions and those who were vulnerable. The practice was open late on some evenings to help those patients who had difficulty getting to the practice due to work or other circumstances. There was a positive approach at the practice to ensure that those patients who needed a flu vaccination were able to access this service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. This person was responsible for the initial investigation and meeting with a complainant if necessary, then to recommend action. This was then ratified by a more senior colleague.

The complaints procedure was available in a prominent place in reception with a form for patients to complete. The policy was also outlined in the practice leaflet to advise patients of the procedure. Patients were encouraged to make any complaint they had either verbally or in writing and all complaints were recorded, even if of a minor nature.

All staff we spoke with on the day of the inspection were aware of the complaints procedure and able to advise patients if asked. They knew who the designated person was who handled complaints and they would normally refer the complainant to them. However there was willingness amongst staff to support patients and deal with any complaint immediately without the need to refer them to the designated person. If a complaint needed to be referred, the designated person was usually available to see a complainant immediately in order to deal with the matter to their satisfaction and to take steps to allay any sense of grievance.

We spoke with several patients on the day of our inspection, who despite not having cause to complain, had the confidence to raise issues with the staff because they were friendly and welcoming. They felt that any issue would be taken seriously and dealt with professionally.

We looked at 11 complaint records that had been recorded since October 2013. We found that all complaints had been recorded regardless of their complexity. We found that record keeping was thorough and included the nature of the complaint, the result of any investigation, the steps taken to satisfy the patient such as an apology and the learning that had been identified. This was then cascaded to relevant staff either personally or at team meetings. Where appropriate it was apparent that some action had been taken immediately to prevent reoccurrence. Record keeping was of a high standard.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision as outlined in their statement of purpose. All staff were aware of the content and involved in working towards it.

The objectives of the practice included providing high quality, effective care and treatment, timely test results and services that met the needs of their patient population. Staff appraisals were linked to achieving the objectives.

The results of the patient survey and the comment cards we viewed confirmed that the strategy was effective and being monitored and reviewed in order to achieve the stated aims and objectives.

Governance arrangements

The practice had identified leads for key performance areas at the practice for both clinical and non-clinical issues. These were safeguarding, child protection, care homes, palliative care, prescribing and information and clinical governance. There were a range of policies and procedures that described the way the practice managed key areas of performance and the standards expected. There was a health and safety policy which had been reviewed and a risk assessment covering the risks to patients and staff. The policies were the subject of regular review and were fit for purpose.

The practice benefited from a practice manager and an assistant practice manager who took responsibility for the day to day running of the practice, with oversight by the GP working there. Reception and administration staff were encouraged and supported to be part of the process and to ensure systems in use were efficient and effective. There was robust monitoring of all systems and procedures and a shared ownership amongst staff members with monitoring of performance by the management team.

Staff we spoke with were aware of the clinical leads and who to speak to if they needed advice. They had been encouraged to read the policies and displayed knowledge about their content. It was apparent that all staff were working towards achieving the standards set for them and that this was being monitored.

The practice had a clear audit timetable for monitoring and assessing the services they provided. A wide range of clinical audits had been undertaken. These included prescribing for diabetes, cholesterol medicine monitoring and the effectiveness of care plans to avoid unnecessary hospital admissions for the elderly and vulnerable. These areas had been re-audited to ensure improvements had been sustained. Several other prescribing audits had taken place including the use of inhalers and other medicines.

Non-clinical audits were also undertaken to improve the services the practice offered. One such audit was designed to reduce the number of patients who did not attend for their appointment. We found that this particular area had been re-audited over the last three years and improvements had been noticed. The audit was carried out quarterly across the GP, nurses and mental health counsellor. As a result of the findings, action was taken to reduce the number of lost hours from cancelled appointments and to decrease the amount of waiting time that patients experienced in obtaining and appointment and waiting to see the GP or nurse. It was evident that the patient register had grown but the number of patients not attending for appointments had fallen.

The appointment system had also been audited to identify peak periods when demand for services increased. These had been identified and staffing levels amended accordingly including the numbers of those answering the phones to book appointments.

An infection control audit took place in 2014 and was the subject of regular review and re-audit. This reflected that the systems and processes in place reduced the risk of health care related infections to patients and staff. Where improvement had been identified these were actioned in a timely manner and learning cascaded to staff appropriately.

The practice manager had started an audit of the use of the alcohol hand gel situated in reception. This involved sitting in reception observing patients and staff over a set period of time to record the use of the gel. The initial findings reflected that staff were using the gel to clean their hands on a regular basis and reduce the risk of infection. The use by patients was quite low and the practice is now considering developing this audit into a patient education exercise by pro-actively asking patients to use it when they attend the surgery. This should decrease the risk of obtaining a health care related infection when attending appointments.

Are services well-led?

Good

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

All of the audits we viewed were completed to a high standard and records were maintained. They contained a robust analysis and attention to detail, followed up by conclusions, areas for improvement identified and action. There were clear identifiable outcomes that not only improved the services they provided but that were having a positive effect on patients.

Leadership, openness and transparency

We found that there was strong, visible leadership at the practice with a positive approach towards teamwork. The managers included all staff in the direction in which the practice was taking towards their vision and all were supported to be involved in any future developments. Regular team meetings took place where all relevant issues were openly discussed. Where a member of staff wished to raise something in confidence, this was dealt with in a way that maintained their privacy.

Staff told us that they felt supported and that their training and development needs were being met and that appraisals were effective and meaningful. They felt included in the future of the practice and that the GP and managers were effective leaders. They told us they could raise any issues either personally or at staff meetings and knew which external organisations to contact if there was a need.

Performance was regularly monitored and all staff were involved. The managers had decided to link performance of the practice with financial rewards to staff and this created an incentive for all to achieve the targets that had been set.

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

The practice sought feedback from patients through a patient survey. We viewed the results for the survey carried out 2014. This showed high levels of satisfaction amongst patients. The areas commented upon included the appointments system, contacting the surgery, waiting times, privacy levels, politeness of staff, the quality of GP consultations and the how the practice managed repeat prescriptions.

As a result of the comments made and the subsequent analysis, there were actions identified to make improvements. This included the ability to book appointments and order prescriptions on-line and monitoring demand for urgent appointments at peak times so that seasonal adjustments could be made.

One particular area of dissatisfaction was in relation to the out of hour's service where patients stated they had experienced problems accessing the service. As a result of the comments, the practice was looking at alternative methods of improving the service, including identifying vulnerable patients where pro-active measures could be put in place to avoid the need to use it.

Each particular area of the survey had been analysed and where services could be improved, action was being taken. All staff at the practice had been involved in learning from the findings of the survey so that improvements could be made by all those working there.

A suggestion box was available in a prominent position at the entrance of the practice for patients to provide ideas for improvement. A form was available for them to complete for this purpose.

The views of staff were sought at appraisals, team meetings and informally. Minutes of meetings we viewed showed that this was taking place. Staff improvement ideas had been documented and actioned where appropriate. Staff we spoke with told us that there was an open culture at the practice that encouraged staff to raise issues and offer ideas where services could be improved.

The practice had not yet started a Patient Participation Group (PPG). This is a group of volunteer patients who meet regularly and discuss ideas as to how the practice could be improved. This is something they were planning to put in place in the future.

Management lead through learning and improvement

The appraisal process was used to positive effect to identify learning and improvement opportunities. Each staff member was encouraged to identify their own learning and development needs and to contribute ideas for improvement.

As the practice had a range of clinical and non-clinical audits, services were monitored and assessed regularly with an ethos of learning and improvement. The leadership at the practice supported all staff to be part of a culture where continuous improvement and learning improved

Are services well-led?

Good

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

services for patients. Staff meetings were used on each occasion to discuss performance and learning and this reflected in the outcomes achieved for patients and the results of the patient surveys

Staff explained to us that they had no fears of recrimination in making suggestions or highlighting safety issues as there was a 'no blame' culture amongst the management team. This created an environment where innovation and learning could flourish which led to improvements in performance.