Woodlands Surgery at Eden House

Quality Report

48-49 Bateman Street
Cambridge
CB2 1LR
Tel: 01223 697600
Website: www.woodlandssurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Woodlands Surgery at Eden House on 19 May 2015. The overall rating for this practice is good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

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

- The practice was a friendly, caring and responsive practice that addressed patients' needs and that worked in partnership with other health and social care services to deliver individualised care.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had very good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of area of outstanding practice:

Summary of findings

- We were told that the lead GP for safeguarding provided their personal contact details to patients with safeguarding concerns. This provided a continuity of care for those requiring this, for example children subject to child protection plans and their next of kin.
- Staff were appointed regular protected training time, if staff were unable to undertake this for unforeseen reasons they would be paid overtime to attend.
- The practice offered additional well being services to patients from its premises. For example yoga and pilates. This was beneficial for patients' wellbeing.
- The practice offered new patient information evenings.

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

Importantly the provider should :

- Improve the arrangements for undertaking appraisals of staff, namely the nursing staff.
- Ensure staff files are complete and up to date, including appropriate pre-employment checks.
- Ensure continuous recording of health and safety matters, for example fire alarm tests.
- Ensure all staff complete training deemed mandatory by the practice, for example equality and diversity training.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had very good facilities and was well equipped to treat patients and meet

Summary of findings

their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people on the safeguarding register. Immunisation rates were in line with local averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We collected 35 comment cards; 32 of these cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. 3 cards were positive but contained negative comments around the quality of care received by different clinicians and referral processes.

We spoke with five patients during our inspection, including two members from the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The patients we spoke with told us that they felt the practice was clean. They also expressed their opinion that the practice provided a very good personal service and that GPs and nurses delivered good clinical care, which acknowledged patients' concerns. The comment cards reflected these views, nearly all with very positive comments. Patients confirmed that they could always get an urgent appointment with a doctor within 48 hours.

None of the patients we spoke with had difficulty booking routine appointments. We spoke with two representatives of the PPG. We were told that they felt listened to by the practice staff, and that the standard of care they received was of a high quality. They provided evidence that the practice had taken their comments and suggestions on board in the past, for example the introduction of name badges and an increase in information provision on the website and in the practice. They were able to evidence support from the practice, specifically the practice manager, with the organisation of PPG related activities.

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for undertaking appraisals of staff, namely the nursing staff.
- Ensure staff files are complete and up to date, including appropriate pre-employment checks.
- Ensure continuous recording of health and safety matters, for example fire alarm tests.
- Ensure all staff complete training deemed mandatory by the practice, for example equality and diversity training.

Outstanding practice

- We were told that the lead GP for safeguarding provided their personal contact details to patients with safeguarding concerns. This provided a continuity of care for those requiring this, for example children subject to child protection plans and their next of kin.
- Staff were appointed regular protected training time, if staff were unable to undertake this for unforeseen reasons they would be paid overtime to attend.
- The practice offered additional well being services to patients from its premises. For example yoga and pilates. This was beneficial for patients wellbeing.
- The practice offered new patient information evenings.

Woodlands Surgery at Eden House

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector. The team included a GP specialist advisor, a practice manager specialist advisor and a second CQC inspector.

Background to Woodlands Surgery at Eden House

Woodlands Surgery at Eden House, Cambridge provides services mainly to patients living in Cambridge city centre. The practice is a partnership of four GPs. One GP partner holds the role of registered manager within the practice. All of the partners are female. The practice also employs three salaried GPs, three nurse practitioners and a healthcare assistant. The clinical team is supported by a practice manager, a patient services manager and a team of administration staff and receptionists.

The practice is a training practice and had three GP registrars in service at the time of our inspection.

District nurses and health visitors are based at the practice and a community midwife runs twice weekly sessions.

The practice has a patient population of approximately 8700. GP appointments are available every weekday between 08:30 and 12:30 and then from 14:55 until 17:30.

Extended hours are provided on Saturday mornings from 09:30 until 12:30. The practice website clearly details how patients may obtain services out-of-hours.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was 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

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

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. During our inspection on 19 May 2015 we spoke with a range of staff including GPs, practice nurses, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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. We found a number of incidents had been reported including issues relating to patient information sharing. The notes included actions that had been taken in response to the incidents to reduce future reoccurrence and improve patient safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last twelve months. We saw evidence that the practice had managed these consistently over time and so could demonstrate a safe track record over time. Staff attended regular meetings where the outcome of significant events and any learning was discussed. Learning from complaints was also discussed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events and complaints and the learning from them was discussed at staff meetings and monitored for common themes and trends. There was evidence that the practice had learnt from these and that the findings were shared with relevant staff.

All clinical and non-clinical staff we spoke with were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. Staff used incident forms on the practice intranet and sent completed forms to the management. We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a recent incident involving information governance of a patient's personal details had led to a review and adjustment of processes to reduce the risk of reoccurrence.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. The practice had held a complaints meetings in April 2015 during which they had reviewed all complaints that were received over the previous year. We saw a summary which included whether complaints were upheld or not and what actions were taken as a result.

National patient safety alerts were disseminated electronically to practice staff and discussed in person. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example a nurse prescriber informed us about an alert that was published on the day of our inspection in relation to Tramadol prescribing. Alerts were also shared in the weekly newsletter to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing, administrative and reception staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern. The practice held quarterly child safeguarding meetings as well as monthly multi-disciplinary meetings during which safeguarding patients were discussed.

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

or those requiring additional support from a carer. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

We were told that the lead GP for safeguarding provided their personal contact details to patients with safeguarding concerns to ascertain a continuity of care for those requiring this, for example children subject to child protection plans. This allowed the patients to contact the GP outside of surgery opening hours in times of need. This assured the patient and their next of kin would receive not only continuation of care as they had experienced but also a familiar doctor to avoid further distress. We were told that this was used in the past by distressed parents of vulnerable children; the GP provided extra support outside of normal hours and visited patients after surgery hours if required.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

The practice provided regular visits to a social housing development and shared any safeguarding concerns that arose there with the local safeguarding team and all staff.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. (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). Staff told us that nursing staff were mostly used when chaperoning a patient. Disclosure and Baring Service checks had been undertaken for clinical staff.

Medicines management

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

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

All prescriptions were reviewed and signed by a GP or nurse prescriber before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had, in fact, adopted the approach to lock all rooms at all times when not in use. Providing optimum security and inaccessibility for patients and outsiders if so required.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, a recent update had led to actions for GPs around the prescribing of Pregabalin.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. Three members of the nursing staff were qualified as independent prescribers and one we spoke with informed us they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept since the practice moved into their current premises in 2013. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a

Good

Are services safe?

lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. They demonstrated a good understanding of their role.

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. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice' s infection control policy.

There was also a policy for needle stick injury. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum.

Auditing of infection control processes was carried out regularly and appropriate action plans had been instigated upon the findings. For example, we saw actions were taken regarding previous bins being too small or not being pedal operated. Audits had been completed in December 2013, May 2014 and April 2015 on cleanliness of practice areas.

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

We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor surgery or other interventions they performed.

The practice did not have a policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in buildings) but did have a risk assessment in place for legionella awareness as well as a certificate for the premises dating back to December 2012.

In certain parts of the building there was an asbestos presence but this had been risk assessed and certified by an external specialist company. No concerns regarding asbestos were raised.

We saw that the practice had arrangements and notices in place for the segregation of clinical waste at the point of generation. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

During the inspection we found records of staff immunisation against Hepatitis B. We found that this was

monitored to ensure staff were protected.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of September 2014. We saw evidence of calibration of relevant equipment was due in June 2015.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were shown evidence of current DBS checks for all staff.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and

non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was an arrangement in place for members of nursing and administrative staff to cover each other' s roles. Staff we spoke with confirmed that this

happened and these arrangements worked well. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

The practice used an electronic system to monitor the use of appointments in correlation with staff leave and the need to organise additional cover. This allowed for effective appointments management.

The current practice manager was due to leave the practice at the end of May 2015. The practice had already appointed a new practice manager who was due to start after finishing their current notice period. The current practice manager was changing roles for personal reasons and confirmed he had been well supported. We saw evidence of succession planning for the role.

Monitoring safety and responding to risk

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

The practice had considered the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed a range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of substances hazardous to health (COSHH). We spoke with both clinical and non-clinical staff about managing risks and found that they had the skills to safeguard patient safety.

Staffing levels and skill mix were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and appropriate levels of staff well-being.

Safety equipment, such as fire extinguishers, was checked and sited appropriately. Health and safety information was displayed for staff to see and CCTV was active within communal areas of the premises. There were no notices in the premises informing patients about the use of CCTV but the practice did have information leaflets available. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

Staff confirmed if they had daily concerns they would speak with the GPs, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinicians in the practice. Staff gave examples of how they responded to patients experiencing an emergency medical situation, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including defibrillators (a defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present) and oxygen were available for use in the event of a medical emergency. The equipment was checked regularly to ensure it was in working condition. All staff had received training in basic life support and defibrillator training to enable them to respond appropriately in an emergency.

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

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of access to the clinical computer system, loss of telephone system and loss of utilities. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. We did notice that the plan contained some out of date information regarding staff contact details; however, we were informed this would be addressed immediately.

Good

Are services safe?

The practice had carried out a bi-annual fire risk assessment in December 2013 and records showed that all staff were up to date with fire training, including dedicated fire marshals. We saw records of weekly fire alarm tests over most periods for 2014 and 2015. There were several months of recordings missing, we were informed by the practice staff that these were mislaid. Staff informed us that these tests had taken place. The fire system was serviced every six months and evacuation drills had taken place twice since December 2013 with all staff being able to name the designated evacuation location.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was discussed at regular meetings.

We discussed with the practice manager, GP and nurses how NICE and other guidance was received into the practice. They told us this was downloaded from the website or received via alerts and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The practice's daily, informal coffee meetings, held for all clinical staff after the morning's surgery, also created a forum for staff to discuss clinical issues and challenges. Although these meetings were not minuted, patient files were updated with plans that were discussed during these meetings.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw the practice completed reviews of case notes for patients, for example those with long term conditions, to show they were on appropriate treatment and had received regular reviews of their health and medicine.

The GPs told us they took special interest on a variety of clinical areas such as women's health and diabetes. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Our review of the multidisciplinary team meetings and clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. Patients were assessed individually according to the risks they presented with and changes made as appropriate to their care plans.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance in the diagnosis and treatment of common chronic conditions and to assess their quality and productivity. Minutes of meetings confirmed this was discussed on a regular basis in the practice.

The practice showed us clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit done on antibiotic prescribing had led to an improvement on adherence to prescribing on re-audit. One of the outcomes of the learning from the audit was a noticeboard containing a list of antibiotics and their indications for use. An audit done on non-steroidal anti-inflammatory drugs (NSAIDS) had led to reduced –and increased safe- prescribing. Other examples included audits to confirm that the GPs who undertook coil implants and minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. The latter audit had led to only one doctor performing minor surgery due to low demand.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit

Good

Are services effective?

(for example, treatment is effective)

regarding the prescribing of non-steroidal anti-inflammatory drugs (NSAIDS). Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. This had led to reduced –and increased safe- prescribing. GPs maintained records showing how they had evaluated the service and documented the success of any changes. Following clinical audit cycles we saw that the outcomes had been discussed, shared and agreed at clinical meetings and the practice was able to demonstrate the learning and changes following the initial audit.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice performed above national and local QOF averages for all clinical domains except hypothyroidism. It achieved 98.4% of the total QOF target in 2014, which was above the national average of 93.5%.

Specific examples of the practice's QOF included:

- Performance for epilepsy related indicators was better at 100% to the national average of 89.4%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was better at 95.8% to the national average of 83.8%.
- Performance for mental health related QOF indicators was better at 98.8% to the national average of 90.5%.

The practice's prescribing rates were similar to national figures. For example, hypnotic prescribing was slightly above national average (0.37% vs 0.28%) but the percentage of Cephalosporins & Quinolones Items as a proportion of antibiotic items prescribed was lower (4.54% vs 5.57%). There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the staff were prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had implemented systems for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. There were no minutes of the palliative care and end of life meetings made available but we found that individual cases were being discussed and care and treatment planned in line with patients' circumstances and wishes. This was recorded on patients' individual files.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory training such as annual basic life support. We noted a good skill mix amongst the staff with a variety of special interests amongst the GPs including dermatology and diabetes.

All GPs were up to date with their yearly continuing professional development requirements and all, either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Most staff undertook annual appraisals that identified their learning needs and from which action plans were documented. Appraisals for the nursing staff were overdue as the lead nurse who undertook these had to take unexpected long term leave. The nurses we spoke with were understanding of this situation and expressed that they felt supported by the other clinicians on site. The day to day management of the nursing team was taken on by the practice manager in the nurse manager's absence. There were no contingency plans in place for undertaking the appraisals. When we raised this with the practice they assured us the nurse appraisal process would be addressed immediately.

Good

Are services effective?

(for example, treatment is effective)

The practice nurses had been provided with appropriate and relevant training to fulfil their roles. One of the nurse practitioners we spoke with explained she was directly mentored by a GP, specifically for her minor illness development and training she was undertaking.

Our interviews with staff confirmed that the practice was proactive in providing training and additional courses. For example, a diabetes course for a health care assistant.

Staff had the availability of a training room in the practice with access to computers to ensure they could undertake e-learning or other developmental activities. Staff were allocated an hour per week of protected training time which was calculated in the rota, if staff were unable to perform this for unforeseen reasons they would be paid overtime to do so. Staff were regularly reminded to undertake learning via the practice manager's newsletter. The practice manager had developed several "how to" guides as additional learning tools for staff.

As the practice was a training practice, doctors who were training to be qualified as GPs were offering extended appointments ranging from ten up to 30 minutes depending on their level and experience. They had access to a senior GP throughout the day for support. The doctors under training commented positively around the support they received.

Reception and administrative staff had undergone training relevant to their role. For example, in response to patient complaints the reception staff had received externally provided customer service training.

Staff described feeling well supported to develop further within their roles.

We reviewed staff files and found that there were some gaps in the collation of the evidence that we expect to see in these files. This applied specifically to inconsistencies around the recording and obtaining of employment references. In one file we did not find an up to date nurse registration certificate for the Nursing and Midwifery Council (NMC). When we checked this member of staff's registration with the NMC we found this to be in date.

Working with colleagues and other services

The practice worked with other services to meet patients' needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X ray results, letters including hospital admissions and discharges, out of hour's providers and the 111 summaries were reviewed and action was taken on the day they were received by the GPs.

The practice held daily morning breaks including all staff which allowed for informal opportunities to discuss patients' care and treatment and seek advice from colleagues. All patient referrals were peer reviewed by the duty doctor to ensure they were appropriate and that alternate pathways had been considered by the original GP.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which had not been followed up appropriately.

The practice worked closely with other local practices; one of the GPs worked as a locum at another practice and the practice held monthly multidisciplinary (MDT) team meetings to discuss the complex needs of patients with the support of an area MDT coordinator. Those patients with palliative care needs or children on the at risk register were also discussed. These meetings were attended by community matrons, district nurses, social workers and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. Decisions about care planning were documented in a shared care record. There was a comprehensive system for managing results and discharge summaries and updating patient records and repeat medicines.

The practice building housed district nurses and health visitors. Other organisations provided their services from the practice's premises on a regular basis. For example, ultrasound diagnostics, psychologists, vasectomy services, counselling services and dermatology.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Good

Are services effective?

(for example, treatment is effective)

record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a consent policy for staff to refer to that explained the different types of consent that could be given. For example, for all minor surgical procedures, the completion of a consent form was required. This covered the understanding of the procedure and any risks involved with it. Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent.

Health promotion and prevention

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering sexual health advice. Smokers were encouraged to see the practice nurse who had received training to support patients wishing to give up smoking.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 15% of patients in this age group took up the offer of the health check. The practice explained the process for following up patients within a week if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 99% of patients over the age of 16 and actively offered health care assistant-led smoking cessation clinics to 25 of these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last year was 9.

The practice identified patients requiring additional support. They kept a register of all patients with a learning disability. There were 19 patients on this register and ten of these had a formal care plan active with the practice. The practice was aware of the remaining nine and kept track of their care by other services that cared for these patients and thus ensured a continuity of care. These patients on the register attended appointments for their annual review of their condition and their on-going treatment was followed up by the practice. Care plans in place were regularly reviewed. In the case of non-attendance these patients were re-invited.

A high percentage of the practice's population were students. It's two largest age groups were 17-25 year olds (25.1%) and 25-34 years olds (24.7%). To reach out to this population the practice used social media and had regular contact with college nurses to support the students' health and well-being.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about support services, such as carer support. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included opportunistic Chlamydia screening for 16-24 year olds. In addition to its NHS services the practice offered a

Good

Are services effective?

(for example, treatment is effective)

variety of wellbeing classes. For example, yoga and pilates. These classes were open for attendance for patients as well as non patients as the practice. The practice did not charge the instructors for the room hire as they wished to encourage the classes in their building as part of their health and wellbeing ethos..

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was slightly below average for the majority of immunisations where comparative data was available. For example:

- The flu vaccination rate for the over 65s was 70.6%, below the national average of 73.2%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 75.6% to 93.3% and five year olds from 80.4% to 96.4%. These were slightly below local averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National Patient GP survey published in January 2015 and a survey of patients undertaken by the practice. The evidence from these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey sent 376 surveys to patients, there had been a 32% response rate. Results showed the practice was rated at 83% for patients who rated the practice as good in comparison to the national average of 85%. The practice performed average for its satisfaction scores on consultations with doctors and nurses with 90% (against 89% nationally) of practice respondents saying the GP was good at listening to them, 88% (against 91% nationally) saying the nurse was good at listening to them, 77% (against 87% nationally) saying the GP gave them enough time and with 89% (against 92% nationally) saying the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 comment cards; 32 of these cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. 3 cards were positive but contained negative comments around the difference of care received by different clinicians and referral processes.

We also spoke with patients on the day of our inspection. All the patients we spoke with told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in a separate office, which helped keep patient information private. Additionally, 85% of patients said they found the receptionists at the practice helpful compared to the national average of 87%.

The practice had a range of anti-discrimination policies and procedures and staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patients' consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of Gillick competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act 2005 and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The results from the 2014 National Patient GP survey which we reviewed showed that patients' responses were below average to questions about their involvement in planning and making decisions about their care and treatment. For example, 82% (against national outcome of 86%) of practice respondents said the GP was good at explaining tests and treatments and 79% (against national outcome of 82%) that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that the GPs were caring, took their concerns seriously and spent time explaining information

Good

Are services caring?

in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards we received was also overwhelmingly positive and each of the patients we spoke with told us that they were happy with their involvement in their care and treatment.

Staff told us that the vast majority of patients registered with the practice were English speaking. They told us that translation services were available for patients who did not have English as a first language. An electronic appointment check-in system was available to reflect the most common languages in the area. Staff had access to an interpretation and translation service.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

84% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.

90% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.

The practice had a system for ensuring that all staff were kept up to date on the status of palliative care patients. This was to ensure appropriate care was delivered and to reduce the risk of any inappropriate contact by the practice staff following a bereavement, for example issuing a letter in the name of the patient.

Notices and information screens in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted clinicians if a patient was also a carer. The practice offered flu vaccinations to carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with who were deemed vulnerable. These registers were used to monitor and respond to the changing needs of patients. Patients on these registers received on the day appointments with allocated extra appointment time if needed.

The practice utilised an electronic medical records system to record and collect information regarding patients. This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care, children who were known to be at risk of harm or those patients who were caring for others.

The practice promoted independence and encouraged self-care for patients through the provision of printed information about healthy living.

In addition to its NHS services the practice offered a variety of wellbeing classes. For example, yoga and pilates. These classes were open for attendance for patients as well as non patients for a small fee. This ensured some of the unused space in the premises was put to good use. The practice did not charge the instructors for the room hire as they wished to encourage the classes in their building as part of their health and wellbeing ethos.

But more importantly it provided a platform for patients to participate in active exercise sessions focussed on wellbeing within their local area.

The GPs at the practice had developed their own in-house specialism such as family planning, sexual health, dermatology and diabetes many of which were of benefit to the wider community as well as the patients registered at the practice.

The practice offered on-line prescribing and appointment booking.

Care and support was offered on site and at local care homes for older people, and at a home for patients with mental health conditions to ensure that the needs of these patients were identified and met. These locations were attended by the doctors and nurses on a responsive and pro-active basis, for example to provide injections.

The practice had been particularly active in identifying those patients who were at risk of unplanned admission to hospital and who had tailored, individual care plans. The patients in this group were recorded on a register and the practice had a system in place for their care plans to be managed during monthly multi-disciplinary team (MDT) meetings. This enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including access to same-day appointments and clinical consultations on the telephone.

Comments cards included positive comments about the leadership at the practice, appointment availability, the skills of the staff, the treatment provided by the GPs and nurses, the smart appearance of the practice, the support and helpfulness of the staff and the way staff listened to their needs. Patients recorded they were extremely happy with the care and treatment they received. These findings were also reflected during our conversations with patients during our inspection.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of patients living with dementia. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review.

We also saw that the premises were excellently configured in a way that enabled patients in wheelchairs to access their GP. There was level access throughout with widened doorways, ramps, an evacuation chair, an accessible toilet, a lift and height adjusted wall fixings so that they were within reach of wheelchair users. There was also a pram park in the practice.

The appointment check in screen was able to display information in a choice of several different languages based on the most common ones in the area. A hearing loop was available in the practice to support patients with hearing loss.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that the practice website had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information about the practice and about NHS primary medical care. The practice had access to the use of translation services if required.

The practice dealt with many patients who were temporary visitors to the area, such as students. The practice assured these patients could access care where this was immediately necessary and treated them as any other patient.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had access to the equality and diversity training but records showed not all staff had completed this.

Access to the service

GP appointments were available every weekday between 08:30 and 12:30 and then from 14:55 until 17:30. Patients could register to book appointments, request repeat prescriptions and view their patient records online. Patients could choose to take telephone appointments.

Following a demand analysis by the practice manager and consideration of patient feedback the practice offered extended opening hours on Saturday mornings from 09:30 until 12:30. The practice website clearly details how patients may obtain services out-of-hours.

The appointment slots on Saturday mornings were 15 minutes as opposed to the standard ten minutes. This allowed for additional checks to be undertaken and the practice stated that the patients attending these appointments tended to have more complex health needs

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

Priority was given to patients with emergencies and to children. Some appointment times were blocked off for this purpose. They were seen on the same day wherever possible. Patients we spoke with on the day told us that they had been able to get appointments for themselves, their family members or their children when required.

The practice had devised and adopted their own triage system, called the Woodlands Triage Triangle. This system created a clear pathway to ensure that the patient was seen by the appropriate member of staff. It included information about differing patient needs and which member of staff could best address this.

Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a an extended appointment where necessary to ensure all healthcare needs could be adequately discussed.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system.

As many of the patients were students, the practice worked together with nursing teams at the universities to provide optimal access for students.

The practice provided access for the local midwife clinic twice a week to provide further care and support to patients during pregnancy.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 99% of respondents say the last appointment they got was convenient compared to the CCG average of 93% and national average of 92%.
- 84% described their experience of making an appointment as good compared to the CCG average of 77% and national average of 74%.
- 66% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 94% said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 74%.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. This was managed by the patients' services manager who made contact with patients that had concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Complaints were discussed at partner meetings every two weeks and the practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

The practice provided new patient information evenings. These events provided an introduction to the practice and the national health service in general. The patients' services manager met with new patients and was active in managing patient expectations.

We looked at 23 complaints received in the last 12 months from patients and found that they had been dealt with satisfactorily. They were all reviewed and discussed by the partners and learning was shared with staff. Apologies were issued to patients where appropriate.

We saw that information was available to help patients understand the complaints' system in the form of a leaflet at the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The vision was embedded around delivering healthcare focussed on holistic wellbeing. It aimed to deliver care above and beyond the standard GP services. We found details of the vision and practice values were part of the practice's strategy. We saw the practice values were displayed on the website and in the practice. The practice had the benefit of having moved to new premises less than two years previous. The vision of the practice was pivotal in the organisation and completion of the new premises. As a result the premises and website were designed to reinforce the feeling of wellbeing and felt reinvigorating and energetic. The premises enabled patients to experience well thought out surroundings.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of partners' meetings held bi-weekly and saw that staff had discussed elements that formed the vision and values to ensure these were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available for staff to read. We viewed several of these policies and found that they had been reviewed annually and were up to date. Policies included infection control, the use of locum GPs, whistleblowing and safety alerts.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP was the lead for safeguarding. Staff we spoke with were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. GPs all had different special interests, for example ENT (ear nose and throat) and they commented that they were often approached by other staff with questions around these specific topics.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. They included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing above national standards in nearly all clinical fields. We saw that QOF data was regularly discussed at bi-weekly meetings and action plans were produced to maintain or improve outcomes.

Team meetings were used to discuss issues and improve practises. We looked at minutes from three team meetings over the last half year and found that performance, quality and risks had been discussed.

The practice had a programme of clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken and drive improvements. These included prescribing and minor surgery.

We were shown the electronic staff handbook that was available to all staff, which included sections on equality, and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of putting patients first. The partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. Staff told us -and we saw that all staff were- encouraged to contribute their views and to have some ownership of the delivery of the practice vision.

Decision making and communication across the workforce was structured around key, scheduled meetings. Practice clinical meetings took place weekly and partnership meetings fortnightly, during these meetings topics such as complaints, premises related matters, QOF data, audits and clinical issues were discussed. The practice held quarterly significant events meetings during which these were discussed and reviewed. Multidisciplinary team (MDT) meetings took place monthly; these meetings were coordinated by an area MDT coordinator and were

Are services well-led?

Good

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

attended by GPs, practice nurses, community nursing teams and the palliative care team. A monthly administration staff meeting ensured all administration staff remained informed and up to date; during these matters such as appointments, scripts and patient communication were discussed. And in addition the practice held six weekly meetings to discuss (child) safeguarding. The practice manager told us other staff meetings were held as and when they were required.

We saw from various meeting minutes we looked at that complaints and significant events were discussed with staff at meetings, via the two logs available for staff and staff were briefed about any changes as and when they occurred through informal briefings and emails.

In addition to staff meetings, the practice featured a daily, informal coffee meeting that took place for a short time each morning. All available staff attended. Any incidents and concerns arising from the previous day or morning's work were discussed and dealt with immediately or escalated for further investigation or more detailed discussion and consideration in a more thorough formal meeting.

We noted that staff were positive in their attitudes and presented as a content workforce. Staff commented that they felt well supported and appreciated in their roles. We considered this to be evidence of the effectiveness of the open and candid approach adopted by the practice.

Comments cards we received included positive comments about the leadership at the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PRGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. It had an active PPG which included a small amount of representatives from a limited variety of population groups; they were actively trying to recruit more members. The PPG met every six months; we were advised that during the last few meetings only three to four members attended.

We were informed that the PPG was going to turn virtual, with the interaction becoming via email and social media. Quarterly meetings were still planned but other communication was to be mainly via email; this was decided with the aim to try and attract more patients to engage with the PPG. We spoke with two members of the PPG and they were positive about the role they played and told us they felt engaged with the practice.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. These include action plans around the introduction of a photograph board of staff members at reception and improved access to appointments.

Staff told us they felt happy they could raise their concerns with the practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the opportunities for learning through protected learning time and the daily coffee breaks which were used to discuss patient cases.

As the practice was a training practice, doctors who were training to be qualified as GPs were offering extended appointments ranging from ten up to 30 minutes depending on the level and experience. They had access to a senior GP throughout the day for support.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. All patient referrals were peer reviewed by another GP to ensure they were appropriate and that alternate pathways had had been considered by the original GP. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working. It was clear to us that everyone who worked at the practice found the daily informal coffee meetings to be of great benefit. This showed that the practice had a dynamic and responsive approach to seeking opportunities to learn and improve.