Nutgrove Villa Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report from our inspection of Nutgrove Villa Surgery. Nutgrove Villa Surgery is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 4 February 2015 at Nutgrove Villa Surgery. We reviewed information we held about the services and spoke with patients, GPs, and staff.

The practice was rated as good overall.

Our key findings were as follows:

- There were systems in place to mitigate safety risks. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice promoted health education to empower patients to live healthier lives.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The practice was well led. The staff worked well together as a team and had regular staff meetings and training.

However there were some areas for improvement.

The provider should:

- Resource additional training and ensure all members of staff receive training in adult safeguarding.
- Carry out risk assessments to ensure staff are suitable to act as chaperones.
- Ensure that the clinical governance policy is revised to reflect the current practice protocols and responsibilities and make all staff aware of this.
- Make better use of the website for patient information and capturing patients' feedback especially with regards to the younger population.

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 people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their needs but further training could be sourced. The practice carried out appraisals for all staff. Staff worked with other local health care professionals on a regular basis.

Are services caring?

Good

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

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 local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity but some of these needed updating or cascading to staff. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received induction training, 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. 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, the avoidance of unplanned admissions scheme. The practice had a designated named GP for patients 75 years and over and care plans were in place for these patients. It was responsive to the needs of older people, and offered home visits and visits to several nursing homes in the area.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. All these patients had a structured annual review to check that their medicines and health needs were being met. For those people with more complex needs, the practice worked with other health care professionals from the community.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Appointments were available outside of school hours and the premises were suitable for children and babies.

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 this group 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 had recently introduced online prescription ordering.

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. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with more complex needs.

The practice regularly worked with other health care professionals in the case management of vulnerable people. It had told vulnerable

Summary of findings

patients about how to access various support groups and voluntary organisations. The practice also recognised the need to support carers and had a variety of support information available in the waiting room.

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 other health care professionals in the case management of people experiencing poor mental health. For example, the practice offered appointments within the practice with the Community Mental Health Nurse. The practice participated in enhanced services for dementia and used screening tools to identify those patients at risk.

Summary of findings

What people who use the service say

As part of our inspection process, we asked for CQC comment cards for patients to be completed prior to our inspection.

We received 11 comment cards and spoke with three members of the Patient Participation Group (PPG). The majority of comments received indicated that patients found the reception staff helpful, caring and polite and some described their care as excellent. However, there were a few comments regarding individual clinical cases whereby patients were dissatisfied with not being referred for further tests in a timely fashion. We discussed this with the PPG who were not aware of any issues.

For the surgery, our findings were in line with results received from the national GP patient survey. For example, the latest national GP patient survey results showed that in January 2015, 87% of patients described their overall experience of this surgery as good (from 109 responses). Eighty eight percent found the receptionists helpful which is higher than the national average and 89% of respondents find it easy to get through to this surgery by phone compared to the Local (CCG) average of **76%.**

Results from the national GP patient survey also showed that 80% of patients said the last GP they saw or spoke to was good at treating them with care and concern which is higher than the national average.

Areas for improvement

Action the service SHOULD take to improve

- Resource additional training and ensure all members of staff receive training in adult safeguarding.
- Carry out risk assessments to ensure staff are suitable to act as chaperones.
- Ensure that the clinical governance policy is revised to reflect the current practice protocols and responsibilities and make all staff aware of this.
- Make better use of the website for patient information and capturing patients' feedback especially with regards to the younger population.

Nutgrove Villa Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor and practice manager specialist advisor.

Background to Nutgrove Villa Surgery

Nutgrove Villa Surgery is located in a purpose built self-contained surgery within the premises of Nutgrove Villa Primary Care Resource Centre in Huyton, Merseyside, which is a deprived area of the country. The resource centre also houses the local walk in centre and the GP out of hours service. There were approximately 3570 patients registered at the practice at the time of our inspection. The practice treated all age groups but there was a larger than average proportion of elderly patients and patients in nursing homes compared to the national average.

The practice has two male GP partners, a practice nurse, reception and administration staff. The practice is normally open 8.00am to 6.30pm Monday to Friday. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider (Urgent Care 24). The practice has a PMS contract and also offers enhanced services for example; various immunisation and learning disabilities health check schemes.

The CQC intelligent monitoring placed the practice in band 3. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band 6 representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the Practice Manager provided before the inspection day. We carried out an announced visit on 4 February 2015.

We spoke with a range of staff including the two GPs, the Practice Nurse, reception staff, administration staff and the Practice Manager on the day. We sought views from representatives of the patient participation group and looked at comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice had a system in place for reporting and recording significant events and information from complaints. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via the practice's computers. The significant event recording form required the member of staff to give a full description of the event and then to record any learning outcomes and action to be taken. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process.

Learning and improvement from safety incidents

The practice held significant event meetings when issues arose which involved the whole practice team when possible. Minutes were stored on the practice's computer system so any staff who missed the meeting could look at the information and in addition the Practice Manager would also update members of staff. We viewed written minutes of these meetings which included details of the events, details of the investigations, learning outcomes and a clear action plan to prevent incidents reoccurring. We looked at incidents that had occurred and found appropriate actions had been taken and new procedures had been implemented to reduce the risk of incidents happening again. For example there had been a training need identified for staff who dealt with out of hours information. The significant events recorded also included positive outcomes.

The practice however did not review the types of events over set time periods to allow identification of any trends which could improve the quality of service provided. The practice did review complaints and identify trends but did not look to see if any of the information held within complaints could be classed as a significant event.

Any information with regards to national patient safety alerts or from the Medicines and Healthcare products Regulatory Agency (MHRA) was collected. Information was then cascaded to the appropriate staff members to ensure any action could be taken if necessary.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were contact numbers displayed in the reception and treatment areas. There was a GP lead for safeguarding but not all staff knew who this was. All staff had received training at a level suitable to their role for child safeguarding, for example the GP lead had level three training. Staff had not completed training for adult safeguarding but there were policies available and staff knew how to act. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. The practice kept a register of patients at risk which was reviewed monthly. The practice held internal safeguarding meetings to ensure patients were being appropriately monitored. For example, the practice held bi- monthly meetings with health visitors to discuss children who may be at risk and also liaised with school nurses.

A chaperone policy was available on the practice's computer system. The Practice Nurse and reception staff acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Some staff had received training but not all staff had been risk assessed to check if they were suitable to carry out this role.

Medicines management

The Practice Nurse took responsibility for the stock controls and fridge temperatures for the storage of vaccines. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use. The Practice Nurse carried out vaccinations for children and had recently received immunisation training updates.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the treatment and consultation rooms and reception area

Good

Are services safe?

for easy access. The Practice Nurse had overall responsibility for ensuring emergency medication was in date and carried out monthly checks. All the emergency medicines were in date.

The practice had an electronic prescribing system but occasionally also used paper prescriptions; these were securely stored and managed.

The practice worked with pharmacy support from the local Clinical Commissioning Group and held meetings both with the Pharmacist and Pharmacy Technician. Audits and reviews of medicines were carried out to ensure patients were receiving optimal care in line with best practice guidelines. For example, audits had been carried out for anti-depressants.

Cleanliness and infection control

The building was owned by a third party who took responsibility for employing cleaning contractors. All areas within the practice were found to be clean and tidy. The Practice Manager carried out monitoring checks to ensure the practice cleanliness was acceptable. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand gels for patients were available throughout the building. Clinical waste disposal contracts were in place and a spillage kit was available.

The Practice Nurse was the designated clinical lead for infection control and had received training suitable for this role. All staff received annual infection control training and there were policies and procedures in place which were easily accessible for all staff on the practice's computer system.

The practice had previously had an infection control audit in March 2014 carried out by the local infection control and prevention team. We could see that any actions necessary as a result of the audit had been implemented. For example, the audit highlighted the need for a separate fridge for samples. The practice had changed the policy for collection so that no samples needed to be stored.

The Practice Manager had a lead role (the GP champion) for infection control for the practice and attended regular meetings with the community team for any updates. The Practice Manager told us the community team sent any e-mails regarding updates and that in future audit questionnaires would be sent to the practice for them to complete.

Equipment

The Practice Manager ensured all electrical equipment had received a portable appliance check to ensure the equipment was safe to use.

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

The Practice Nurse carried out monthly checks on emergency equipment such as the oxygen and defibrillator.

Staffing and recruitment

The practice had two GP partners and a Practice Nurse. The clinical members of staff were supported by reception and administration staff and a Practice Manager. Members of staff told us there were enough staff to meet the needs of patients and covered each other in the event of unplanned absences.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included information about Disclosure and Barring Scheme (DBS). The practice had a new employee checklist to ensure all relevant documentation and processes were carried out including proof of identification as well as ensuring staff received information regarding confidentiality and health and safety. We looked at recruitment documentation files which were well organised and found all necessary checks had been carried out. The practice also checked the annual professional registration status for nurses. Some staff acted as chaperones but there were no risk assessments in place to ascertain whether they required further employment checks.

Monitoring safety and responding to risk

Good

Are services safe?

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff and the Practice Manager had printed the Health and Safety leaflets which had been signed by staff to say they knew about the policies in place.

The building was owned by a third party who carried out all building safety maintenance checks. This included fire risk assessments and testing of fire equipment. The practice also carried out regular fire drills.

The practice had taken part in an audit in conjunction with the local clinical commissioning group to ensure that it was following best practice guidelines for the cold chain storage of vaccines and use of emergency medicines.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There were accessible flow charts available to guide staff to deal with medical emergencies for patients in the surgery or for patients describing symptoms on the telephone.

All staff received annual basic life support training and there were emergency drugs available in the treatment and consultation rooms and reception areas. There were also quick reference guides for staff for correct doses of adrenalin for treatment of anaphylaxis. The practice had oxygen and a defibrillator available on the premises. The practice had recently taken part in an audit with the local clinical commissioning group to ensure that they were following best practice guidelines for the types of emergency drugs required. There was a first aid kit and accident book available.

The practice had a comprehensive disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do if faced with a major incident. A copy of the plan was kept off site to refer to should there be no access to the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the Practice Nurse carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. The Practice Nurse referred the patient to the GP when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register.

Clinical staff met on an informal basis throughout the day if there were any concerns regarding individual patient management. The practice took part in the avoiding unplanned admissions scheme and held regular meetings with other health care professionals to discuss patient's needs and to ensure care plans were in place and regularly reviewed.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. The practice results for QOF totals (2013-2014) were slightly lower than the local average and national average and the results from our intelligent monitoring systems showed there were some areas of concern. However the GP partners had only been at the practice for two years and had made some improvements in this time. They had introduced regular meetings with the Practice Nurse to discuss practice performance and improvements in QOF for chronic disease management and to ensure targets were met. For example the intelligent monitoring system had highlighted areas of elevated risk with diabetes management. In discussions with the Practice Nurse, we could see the practice was aware of the issues and had taken steps to rectify any shortfalls.

GPs carried out clinical audits. Examples of audits included antidepressant prescribing. Patient case reviews were carried out and where appropriate switches to alternative recommended first choice antidepressants were made. Learning points from clinical audits were routinely discussed at staff meetings.

The practice also met with the local Clinical Commissioning Group (CCG) to discuss performance and held a PMS plus contract whereby the practice was awarded for improving outcomes for example increasing the uptake of screening for various cancers and immunisation rates.

Effective staffing

The practice had a comprehensive induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. The practice provided an employee handbook to facilitate their learning.

All staff received training that included: - safeguarding vulnerable children, basic life support, information governance awareness and infection control. However we saw that training for safeguarding needed to be updated and to also include safeguarding for adults. The practice attended training sessions organised by the local clinical commissioning group every three months. The Practice Manager attended local forums with managers from other practices in the area.

The Practice Nurse attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (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).

There were embedded appraisal systems in place. The Practice Manager oversaw the appraisals of all non- clinical staff and the Practice Nurse received their appraisal from the GP partners.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

Incoming referral letters from hospitals for example that required action from the GP such as a change in medication were immediately passed to the GP prior to scanning the information onto the patient's notes. The practice had one member of staff who specifically dealt with the scanning of letters to avoid backlogs and ensure the GPs were kept up to date with patient information. The practice had access to patients' tests results and had a system in place for recording information on to patients' medical records. Cases which required immediate follow up were flagged up on the practice's computer task system for the GP to action. Each GP could access their patients' follow up requirements. Urgent information was given directly to the GP. Patients were contacted as soon as possible if they required further treatment or tests.

Patients were referred to hospital using the 'Patient Choose and Book' system and used the two week rule for urgent referrals such as cancer. The practice had monitoring systems in place to check on the progress of any referral. Comments we received about referrals were mixed; some patients we spoke with were happy others dissatisfied with not being referred for further tests in a timely fashion. We discussed this with the Patient Participation Group who were not aware of any issues.

The practice liaised with other healthcare professionals such as a Community Diabetic Specialist who attended the practice once a month and worked with the Practice Nurse to help manage treatment. There was a visiting Midwife and Health Visitor who worked together to identify any patients who required extra support.

Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. There were clear guidelines for staff regarding information governance and the sharing of information displayed in the reception offices. Information about individual clinical cases was shared at staff meetings. For example, the practice in conjunction with community nurses and matrons held regular multidisciplinary Gold Standard Framework meetings for patients who were receiving palliative care and minutes of these meetings were available to all staff involved.

The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice liaised with the out of hours provider regarding any special needs for patients.

The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer.

Consent to care and treatment

The practice had a Mental Capacity Act policy in place and we spoke with the GPs about their understanding of the Mental Capacity Act 2005. They provided us with examples of cases where best interest meetings had been held that demonstrated their understanding around consent and mental capacity issues.

The GPs were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice carried out minor surgery and we found appropriate information and consent forms for patients were in place.

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations. The practice also had a website but this was basic in terms of providing further patient information or signposting to other services.

The Practice Nurse held clinics for a variety of chronic diseases such as diabetes and chronic obstructive pulmonary disease. The practice also operated NHS health checks for patients between 40-74 years of age.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the national GP patient survey (from 109 responses) also showed that 80% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 85% said the last GP they saw or spoke to was good at listening to them which is higher than the national averages.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 78% said the last GP they saw or spoke to was good at explaining tests and treatments and 75% said the last GP they saw or spoke to was good at involving them in decisions about their care which was slightly lower than the local average . Eighty nine percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was higher than the local average.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

Patient/carer support to cope emotionally with care and treatment

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. The Practice Manager told us that patients with emotional issues were contacted and could be signposted to various bereavement counsellors and support organisations to ensure their needs were being met. There was information available in the waiting room for various support organisations for bereavement.

There was a separate notice board in the waiting room with supporting information to help patients who were carers. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available in the waiting room and on the practice's website. The PPG met quarterly and patient surveys were sent out annually. There was a designated notice board within the waiting room for information about the PPG and the results from patients' surveys.

We spoke with three members of the group who told us the practice management had been responsive to any of their concerns. For example the practice had installed a sign asking patients to step away from reception when other patients were at the desk to attempt to gain better privacy during conversations.

Tackling inequity and promoting equality

The surgery had access to translation and also sign language services. The building had disabled facilities including appropriate access.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

Access to the service

The practice was open 8.00am to 6.30pm Monday to Friday. Patients could make appointments either by telephone or by visiting the practice. The practice was flexible about making appointments for patients and carried out any opportunistic screening or gave advice where possible to avoid patients having to make further appointments. Urgent appointments could be made on the same day and if all the appointments were gone, the GPs would call patients. Priority was given to children, the elderly and those patients with more complex medical conditions. There were notices in the waiting room to advise patients that if they had more than one medical problem that needed attention, they should book a longer appointment. The Practice Manager told us the practice was planning to install an online appointment booking facility by the end of March 2015. Results from the national GP patient survey showed that 89% of respondents find it easy to get through to this surgery by phone compared to the local Clinical Commissioning Group (CCG) average of **76%.**

The practice carried out telephone consultations and home visits when necessary. The GPs also carried out visits to several nursing homes and sheltered accommodation in the area. We saw that patients were not kept waiting to be seen for their appointment and that they were given an indication as to how long they would have to wait when they arrived. Results from the national GP patient survey showed that 83% of respondents usually wait 15 minutes or less after their appointment time to be seen compared to the Local (CCG) average of **63%.**

Listening and learning from concerns and complaints

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

Information about how to make a complaint was available on the practice's website and in the waiting room. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

Learning points from complaints were discussed at staff meetings and all patients were written to with an explanation and apology when things had gone wrong.

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

According to the practice's statement of purpose, the practice aimed to provide safe, high quality of care that met the needs of the patients. Staff we spoke with confirmed this and described the practice as a friendly family practice aiming to provide a high quality service. Comments we received were very complimentary of the standard of care received at the practice.

The two GP partners had only been in charge of the practice for the past two years and during this time had concentrated on improving the quality of clinical care. Improvements had been made and although the GPs were clear about what type of service they wanted to provide they had not formalised a business plan for the future. The practice did however hold regular business meetings. The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs.

Governance arrangements

The practice did have a clinical governance policy in place but this needed updating to reflect who the lead was. The governance policy covered: patient involvement, clinical audit, staffing, education and risk assessments but was generic and needed to reflect the individual practice arrangements.

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy and 'Infection Control' policy. The practice Manager told us policies were reviewed when necessary or at least once a year when possible. The practice had very recently moved to an online repeat prescription service and the Practice Manager was aware the repeat prescribing policy needed updating.

Leadership, openness and transparency

Staff had specific roles within the practice for example lead for infection control. However we found that some staff were not aware of other members of staff's roles. For example who the lead for safeguarding was.

Staff we spoke with told us they were well supported in their roles. For example, the GPs operated an open door policy so that the Practice Nurse could discuss immediately any concerns about patient case management.

The practice had a protocol for whistleblowing which was contained within their safeguarding policy. Staff we spoke with were aware of what to do if they had to raise any concerns but were not aware of the existence of the policy.

The practice had monthly staff meetings to ensure all staff had an opportunity to be involved in the running of the practice. Minutes for all meetings were kept on the practice's computer systems which all staff could access. When any incidents occurred, meetings were held with the whole practice team to discuss any actions necessary.

Members of staff were supported at the practice for example there was a 'zero tolerance policy' to prevent and cope with any untoward behaviour from patients against the practice staff. Staff we spoke with thought the culture within the practice was open and honest.

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

Results of surveys and complaints were discussed at staff meetings. There was a patient participation group in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with three members of the Patient Participation Group (PPG) who told us the main concern was not having a female GP. The practice was addressing this issue. The PPG felt that the practice was responsive to any issues raised by the group.

The practice reception staff encouraged all patients attending to complete the new 'Friends and Family Test' survey as a method of gaining patients feedback. We saw that the Practice Manager constantly reviewed the information received and we noted all comments had been positive. The Practice Manager told us that results would be discussed with the PPG in the future and results displayed for all patients.

Management lead through learning and improvement

The practice had previously had several owners and there had been quite a few changes to the GPs at the practice over the years. The two GP partners had taken over the practice in 2012 and had introduced stability in terms of patients seeing the same GP. The GPs had realised

Are services well-led?

Good

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

improvements had been needed and had worked hard to achieve their aims. For example, the practice was part of a contract scheme called the PMS plus scheme for the area and had moved up the grading levels as screening rates for cancers, immunisations and medication management had improved.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and ensured the whole team was involved in driving forward improvements. They recognised future challenges and held regular business meetings to plan ahead.