Princes Gardens Surgery

Quality Report

2a High Street
Aldershot
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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 a comprehensive inspection of Princes Gardens Surgery, 2a High street, Aldershot, GU11 1BJ on 22 October 2014.

We found that Princes Gardens Surgery is a good practice overall with a strategy and track record of continuous improvement for the care and responding to the needs of patients living in the area.

Our key findings were as follows:

- Patients were complimentary about the care and support they received from staff.
- Staff told us they were committed to providing a service that put patients first.
- The practice responded to the changing needs of the different populations groups that used the practice.
- There were examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it has made a difference or not.

We saw several areas of outstanding practice including:

- The practice had employed a Nepalese receptionist as well as access to language line to assist with Nepalese patients.
- The practice had a large Nepalese population group and information had been translated in order for this group to obtain relevant information.

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 safe.

Entry and exit to and from the reception and waiting areas were all on one level. There was a clean and tidy waiting area.

Staff we spoke with were trained in and aware of their responsibilities for safeguarding of vulnerable adults and children. There were systems and processes in place to raise concerns and there was a culture of reporting and learning from incidents within the practice.

Staff followed suitable infection control practices and the equipment and the environment were maintained appropriately.

Vaccines, medicines and prescriptions kept on the premises were stored suitably and securely. There were suitable systems for the receipt, storage, record and administration of vaccines.

The practice had suitable arrangements in place for dealing with emergency situations and we saw policies in relation to reacting to any interruption to the service provided.

Are services effective?

Good

The practice is rated as good for effective.

There were sufficient staff who received regular training and on-going support through an effective appraisal system.

There were systems in place to ensure there were sufficient staff to meet patient needs. Patient needs were assessed and care and treatment was delivered in line with current legislation and best practice.

The practice had systems and processes in place to make sure that standards of care were effectively monitored and maintained.

The practice worked with other health and social care professionals and organisations to ensure that their patients received the most effective support and treatment.

Information was shared with relevant stakeholders such as the local clinical commissioning group and NHS England.

Are services caring?

Good

The practice is rated as good for caring.

Summary of findings

Patients we spoke with told us that they were well informed about their care and treatment. We observed people being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient privacy, dignity and confidentiality when registering or booking in patients.

All the patients we spoke with, and the comments we received were complimentary of the care and service that staff provided.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice understood the needs of their patient population and this was reflected in the setup of the practice environment and systems used to meet some of the needs of their patients.

Patients told us they could always get an emergency appointment and waiting time for routine appointments was satisfactory.

The practice obtained and acted on patient's feedback. The practice learned from patient experiences, concerns and complaints to improve the quality of care.

Are services well-led?

Good

The practice is rated as good for well-led.

There was a clear leadership structure and staff felt supported by management and a culture of openness and honesty was encouraged.

The staff worked as a team and ensured that patients received a high standard of care. Staff had received inductions, regular performance reviews and attended staff meetings.

Risks to the safe and effective delivery of services were assessed and addressed in a timely manner. A suitable business continuity plan was in place. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place.

The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older 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. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions.

Patients in this population group received a safe, effective care which was based on national guidance. Care was tailored to patient needs, there was a multi-disciplinary input and was reviewed regularly.

The practice provided regular clinics for patients with diabetes, respiratory and cardiac conditions. The practice had a diabetes nurse and three doctors who were had received training and provided diabetic care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

The practice followed national protocols and staff were aware of their responsibilities and the various legal requirements in the delivery of care to people in this population group. They worked with other health and social care providers to provide safe care.

Immunisation rates were relatively high compared to the national level for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. We were provided with 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 population group of the working age people (including those recently retired and students).

Summary of findings

There was an appropriate system of receiving and responding to concerns and feedback from patients in this group who had found difficulty in getting appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the population group whose circumstances may make them vulnerable.

There was evidence of good multidisciplinary working with involvement of other health and social care workers. Staff were trained on safeguarding vulnerable adults and child protection.

The practice visited local charities to see patients who found it difficult to attend the practice. The practice oversaw the care of some patients who resided in a protective environment.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including patients with dementia).

The practice ensured that good quality care was provided for patients with mental health illnesses. The practice had a nominated lead for linking with other health professionals and community teams to ensure a safe, effective and co-ordinated service. The practice offered proactive, personalised care that met the needs of the older people in its population and had a range of enhanced services, for example in dementia. Data showed that this practice had a better than national average score for dementia diagnosis rate adjusted by the number of patients in residential care homes.

Summary of findings

What people who use the service say

During our visit we spoke with seven patients, including one member of the patient participation group and reviewed 39 comments cards from patients who had visited the practice in the previous two weeks. All the feedback we received was positive. Patients were complimentary about the practice staff team and the care and treatment they received. Patients told us that they were not rushed, that the appointments system was effective and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

Patient satisfaction was rated and 91 to 97.6% rated the service they received by the GPs as good or very good (also satisfied or very satisfied).

Outstanding practice

Taking account and responding to patient needs and wishes throughout their care and treatment.

We saw that across the population groups the practice had worked to provide outstanding response to the needs and wishes of patients.

The practice had employed a Nepalese receptionist as well as access to language line to assist with Nepalese patients.

The practice had a large Nepalese population group and information had been translated in order for this group to obtain relevant information.

The practice worked with two local centres to assist homeless patients who were adults and young adults.

Princes Gardens Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP, and a specialist advisor practice manager and a second CQC inspector.

Background to Princes Gardens Surgery

Princes Gardens Surgery, 2a High Street, Aldershot, Hampshire is a general practice that provides NHS services. It is a purpose built surgery located close to the centre of Aldershot.

The practice had been a training practice since 2005 and at the time of our visit had six doctors, five female and one male. All the consulting rooms and waiting areas afforded good disabled access. The practice had about 8,500 patients on its list. The practice patient list had increased in the three years that the practice had been in the location from 6,000 to 8,500 with a rapid increase in 2014. At one point 20 new patients were registering each day which put pressure on reception, administration and clinical staff. The practice became concerned that the high standards of care they aimed for in offering appointments and updating patient notes was being affected. The practice therefore made a case to NHS England and was allowed to close the patient list until March 2015.

The practice took action to increase the reception staff, administration and nursing hours. One partner retired in April 2014 and a salaried partner was employed, this person moved to a partnership in another place. A new very experienced partner had been appointed and commences work in January 2015.

Out of Hours urgent medical care was offered by another provider when the practice is closed from 6:30 pm to 8 am, Monday to Friday and all day and night at the weekends and public holidays.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked the practice to send us information about themselves, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 22 October 2014.

During our visit we spoke with a range of staff including GPs, practice nurses, practice manager, administration staff

Detailed findings

and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People living in vulnerable circumstances

• People experiencing poor mental health (including people with dementia)

The practice was in the third level less deprived area according to UK statistics. They had more than the UK average of patients up to the age of four, as well as in the age group from 20 to 34 years. 51% of the patients were listed as having long-term conditions; the UK average is 53.5%. Unemployment rate is low (2.9%, compared with a UK average of 6.38%). QOF achievement is 99.68% (UK average is 96.44). Vaccination rates range from 89-97%, the sole exception being meningitis C vaccination at 79%.

They were good at diagnosing dementia and register higher than the UK average. They had a register for learning disabilities for the patients aged 18 and over. They had a palliative care register and multidisciplinary meetings.

Good

Are services safe?

Our findings

Safe Track Record.

The registered manager and senior GP worked closely with the practice manager on governance at the practice and monitored incidents, near misses and significant events. The practice GPs met on a regular basis to discuss safety of patients and safe care of patients. Any learning points were discussed openly and any actions were taken and systems changes were made where appropriate. There were examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it has made a difference or not. We saw evidence of reflection at the end of the full cycle, regardless of whether the desired change was achieved not. An example seen was the cancer audit/review which was completed in October 2013; as a result of this all-new diagnosis of cancer were discussed. The practice used Monday meetings to retrospectively look at some previous consultations for these patients and decided whether an opportunity was missed to diagnose them even earlier and what lessons could be learned from this.

Learning and improvement from safety incidents.

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. We saw an example where systems within the practice had been changed to minimise further risks.

Reliable safety systems and processes including safeguarding.

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding had taken part in specific high level training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Examples were given by staff of safeguarding concerns they had raised. Any case of concern is also discussed during the Monday clinical meetings.

Staff were also aware of the practice “whistleblowing” policy and understood it.

The practice offered patients the services of a chaperone during examinations if required. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw that details of this service were displayed around the practice building for patients to read and staff told that this service was offered to patients.

Medicines Management.

Arrangements were in place in relation to the management of medicines at the practice. These included safe storage, records and disposal.

The practice maintained a log of refrigerator temperature checks, daily during practice opening hours. Staff were aware of protocols to follow if the refrigerator temperature was not maintained suitably. We saw that the medicines cupboard and the vaccines refrigerator in the nurse's treatment rooms were securely locked.

We checked the emergency medicines kit and found that all the medicines were in date. There was a log maintained with the expiry dates of all the medicines available in the kit. The vaccinations were stored in suitable fridges at the practice. All the medicines and vaccines that we checked were within their expiry date.

There was a GP lead for prescribing and regular audits and reviews of the prescriptions of people with long term conditions was undertaken using the data collection tools on the practice computer systems. Yearly prescription reviews were undertaken.

Prescription pads were securely kept in a locked cupboard within a designated area of the practice.

Cleanliness & Infection Control.

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection.

Good

Are services safe?

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises and especially the nurses' treatment room appeared very clean and well maintained. Work surfaces were easily cleanable and were clutter free. The room was well organised with well sighted information and clean privacy curtains, sharps box and foot operated waste bins. We spoke with one of the nurses who clearly described the procedures in place to maintain a clean and safe working environment.

Hand washing guides were available above all sinks both in clinical and patient areas. There was a good supply of bacterial soap pump dispensers and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was good segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

Equipment.

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurses to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise. The practice had an Automated External Defibrillator (AED) an AED is used in the emergency treatment of a person having a cardiac arrest.

Regular checks were undertaken on the equipment used in the practice. Examples of recent calibration checks of equipment by a contactor were seen. Risk assessing took place in the different areas of the practice and we saw evidence of the assessments in the health and safety file.

Staff had taken part in emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice.

Staffing & Recruitment.

The provider had a suitable process for the recruitment of all staff. The practice carried out pre-employment checks which included appropriate references, and where required criminal record checks, such as using the Disclosure and Barring Service. Newly appointed staff received an induction which included explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures.

The staff we spoke with told us that they had worked at the practice for a number of years and some had moved with the practice to the new building. The practice manager and GPs we spoke with told us that they felt the stable and experienced work force provided a safe environment for their patients. Staff at this practice worked as a team to cover the practice opening hours and would adjust their hours to cover any sickness or annual leave.

Monitoring Safety & Responding to Risk.

Risk assessments were carried out for safety in the practice and emergency procedures were carried out such as fire alarm testing and evacuation procedures. Changes to risk were monitored and responded to as and when required.

The practice conduct regular fire drills to ensure fire safety was high . Fire risk and legionella assessments were found. Equipment testing and fire extinguisher testing were up to date. An up to date and resolved accident book was available behind reception.

Arrangements to deal with emergencies and major incidents.

The practice had appropriate equipment, emergency drugs and oxygen to enable them to respond to an emergency should it arise. We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service.

This plan had been recently tested when there was an electricity outage in the building. Staff told us that the incident helped them to have confidence that the continuity plan was robust and worked.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment.

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence. The practice had regular meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of people.

The meetings covered various clinical issues, an example seen was in regards to individualising new patient care; all new patients were offered new patient checks, NHS checks as appropriate (of which there was good uptake). Chronic disease management appointments offered as appropriate, as well as GP appointments when required. The practice had also employed a Nepalese receptionist as well as access to language line to assist with Nepalese patients.

Management, monitoring and improving outcomes for people.

The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. The practice carried out regular clinical audits to ensure the treatment they offered patients was in line with relevant guidance. There was evidence of learning from the audit process. Examples seen were Data collection re Cancer Diagnosis at Princes Garden. Audit of Prescribing for coeliac at Princes Gardens surgery and audit of the use and monitoring of atypical antipsychotic drugs at Princes Gardens surgery.

The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care for example, by exploring clinical changes for conditions such as diabetes. The practice used to the QOF to evidence that they had a register of patients aged 18 and over with learning disabilities, had a complete register of available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed.

Effective staffing.

The staff told us they had received this training and how much they enjoyed their variety of work. Staff we spoke with all told us that they felt well supported by their colleagues and the practice manager. They said they had been supported to attend training courses to help them in their professional development and that there was a culture of openness and communication at the practice and they felt comfortable to raise concerns or discuss ideas.

Staff received appropriate support and professional development. The provider had identified training modules to be completed by staff which included amongst others safeguarding of children and vulnerable adults. Staff were aware of and had received information about safeguarding and training in infection control and basic life support skills. Staff received supervision and an annual appraisal of their performance.

Working with colleagues and other services.

The provider worked in co-operation with other services and there was evidence of good multi-disciplinary team working such as working with a local hospital. Arrangements had been set up for hospital consultants to be available for telephone discussions, so as to avoid admissions if possible. This was especially helpful with geriatricians who were able to offer advice and even an appointment to a hot clinic if appropriate. For example a Respiratory "Hot" Clinic. This service is available to GPs and Community Matrons to refer patients they feel meet the referral criteria. It is intended to prevent the admission of patients with acute respiratory problems and is suitable for referral of adult patients threatening admission with a respiratory problem. Patients are discharged from the clinic with a management plan drawn up by a Respiratory Consultant.

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement of other social and healthcare professionals especially in the care of the elderly.

Information Sharing.

Where required information was shared in a responsible and comprehensive way. An example seen was that care plans for vulnerable were shared and uploaded to ambulance and Out of Hours.

Good

Are services effective?

(for example, treatment is effective)

The practice lead on information governance explained that staff were given training and discussed confidentiality. Staff we spoke with were able to explain the training they had received about information sharing. An example given was that when insurance companies requested details of patient notes no information was released without first obtaining full consent from the patient and checking with the GPs.

Another example was there were notes alerts for vulnerable patients. There were also warnings in the notes about patients who were particularly vulnerable and how the practice was active to protect their safety.

Consent to care and treatment.

Staff were aware of how to obtain patients consent for treatment and care and could describe actions that they would take. Staff were aware of Mental Capacity Act 2005 and although not all staff had received formal training, they could demonstrate the principles, and knew about use of advocates when needed.

We spoke with nurses who demonstrated a good understanding of their responsibilities for obtaining valid consent from patients, and a patient we spoke with confirmed that they understood about giving consent and did not feel pressured into agreeing to treatment. We were told that if the GP or the nurses deemed the patient did not have capacity to consent then they discussed the matter with the next of kin, carers as well as fellow professionals.

All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention.

Notices were visible. An information leaflet rack was full and up to date with a good variety of information. The practice had a large Nepalese population group and information was seen that had been translated in order for this group to obtain relevant information. The Nepalese receptionist showed us information leaflets that had been translated for those patients that required them. The receptionist was also able to provide Nepalese patients with their appointment information in the language of their choice.

The practice ensured that where applicable people received appropriate support and advice for health promotion. Information available to patients was effective; there was an extensive pin-board on the wall in the waiting room which was tidy, up to date, and contained notices relevant to the demographics of the patients.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy.

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk, and patients were directed swiftly. The reception was accessible to patients with disabilities with lower desk height for wheelchair users. There were signs that asked for patients to respect the privacy of other patients. The practice had a room set aside for patients to use if they required further privacy to discuss any matter.

Although the receptionist took phone calls at the desk, confidentiality was maintained as at no time did they mention any name or diagnosis or treatment.

They practice ensured that the Out of Hours service was aware of any information regarding their patients' end of life needs. This meant that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment.

All the patients we spoke with and the comment cards completed were complimentary of the staff at the practice and the service received.

Patients told us that they felt listened to and involved in the decisions about their care and treatment. Patients expressed their views and were involved in making decisions about their care and treatment. Patients were given appropriate information and support regarding their care or treatment. Patients told us that the doctors took time to explain things to them. Patients said they had the opportunity to ask additional questions if they needed to and felt their concerns were listened to.

The practice offered patients choices with choose and book office options with regard to hospital care services. The practice had on site physiotherapy as well as an option for external services. The patients are also able to choose which doctor or nurse to see rather than having to be part of a named doctors list.

Patient/carer support to cope emotionally with care and treatment.

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients had been contacted by the practice and care and treatment needs were followed up.

The practice provided emotional support in all groups. The practice aimed to support patients well and according to their wishes. For example. An older patient became unwell over a weekend and deteriorated swiftly. They were not keen to go to hospital and wished to be cared for at home. The practice with the help of the district nurses and the primary care palliative liaison adviser enabled the patient to remain at home with suitable pain relief and palliative care until they passed away. The practice was able to manage the patient's needs despite the urgency and speed of this request.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs.

The practice had worked with a patient participation group to produce a practice survey for the wider practice population. The patient survey undertaken in 2013 showed that patients were happy with the service and that it met their needs. We also found this to be the case in our discussion with patients and from the comment cards submitted by patients attending the practice on the day of our visit.

The practice had actively taken a lead to raise awareness of issues concerning the Nepalese families through the local citizen's advice bureau. They were given resources through the local clinical commissioning group as well as Hampshire county council and a DVD with Nepalese actors was produced. The practice planned to share the DVD with Nepalese patients. It has been shown at a local Nepali community event already. It discusses issues regarding diabetes, prostate cancer, and men's health. The practice was aware of the sensitivities about discussing male health issues in front of female patient and vice versa; this was important for this the Nepali community.

The practice has recently employed a Nepalese receptionist who was an ex-Ghurkha soldier. This person has been exceptional as a translator because he translated word for word rather than trying to filter what was said and provided his own filtered view of what the patient said. The receptionist had also produced written documents and pamphlets in Nepalese for the information of the patients. A Nepalese patient spoken with was very happy that the practice had provided the assistance as it meant that the patient understood everything and was able to explain everything. This is an example of how the practice had met the health needs of the patient group.

Child immunisations were called regularly and non-attenders were notified to the Health visiting service. The practice was achieving more that 90% of its immunisation cohort.

The practice nurse responsible for child immunisations constantly chased records of patients whose vaccination regime was started outside of the UK to ensure the safety and completeness of the vaccination programme. Midwives attended the practice on Wednesday and Fridays. When parents were unable to bring children for immunisations and they were brought by a third party, written consent was always requested. The nurse then phoned parents on the day of immunisation to check consent verbally and to go through details of the procedure. Immunisation clinics were normally done alongside a GP doing eight week checks so that they were available if there were any concerns that the nurse wished to discuss.

Tackling inequity and promoting equality.

The practice worked with two local centres to assist homeless patients who were adults and young adults.

They also worked with a charity set up to empower homeless people and those facing adversity to achieve their full potential and teenagers aged 16 to 18 for whom they offered support services.

The community matron met with the practice once a month, as well as district nurses, the primary care palliative care liaising for end of life care discussions. The GP also attended locality meetings every six weeks as well as clinical commissioning group forum meetings every eight weeks for an afternoon session. A practice council sat on the same day in order to discuss practice, local or locality issues that were then tabled at the forum.

The premises and services had been adapted to meet the needs of patients with disabilities. The reception area had been designed to have lower levels for patients in wheelchairs or on mobility scooters to be able to peak with the receptionist at the same level. All the corridors were wider and the toilet facilities were designed to be fully accessible to meet the needs of patients with disabilities.

Access to the service.

The phones to the practice opened at 08:15 am with an emergency line being available from 08:00 am. The practice doors opened at 08:30 am and closed at 6:30 pm. The phones and the practice remained open including through the lunch time. Patients requiring assistance outside the practice hours were directed to the Out of Hours provider.

The practice also had extended hours. One evening a week until 8:00 pm and every other Saturday for 2 hours. During flu season, all of the GPs and nurses worked on a Saturday to administer flu vaccinations. Nepalese patients were given priority during the first hour of the clinic to allow for the language barrier to be overcome.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Online access allowed patients to request repeat medication or book appointments which gave patients some access at all times. The practice manager told us that they regularly review their appointment system to ensure that the appointments were in the right place.

The practice did implement a third receptionist at the PPG's request to answer the phone.

A priority phone had been installed to allow over 75 year old patient to make quicker access to the surgery. Certain teams within the practice had direct dial numbers to make it easier for patients to phone in to prescription clerks and secretaries.

The GPs worked to enable continuity as well as choice; for example if a GP knew a patient well and had seen them recently, if that patient called for telephone triage with another colleague they would pick up this call themselves to preserve continuity of care.

The practice ran an on-call GP service that was split into parts: the morning part from 8:00 am to 2:00 pm and the afternoon part ran from 2:00 pm until 6:30 pm. There were no gaps between their provision and the out of hour's revision. All the letters in the day went to the on-call GP, except for those addressed to specific GPs who were working that day. The on-call GP also did most of the telephone triage and the entire home visits; if there was a high demand the other GPs took a share. The evening on-call GP in the surgery, dealt with phone calls and the occasional home visits that were required. These were done at the end of the day on the way home.

Emergency slots were available every day for vulnerable patients that were only able to make an appointment by walking in. Patients who needed support with drug and alcohol problems were able to access a fully integrated drug and alcohol abuse service. There were specific teams available for patients needing urgent assistance with mental health problems.

The practice called all patients that were eligible for flu vaccinations who had not had one by November. This was done mostly by letter, but the over 65years old were telephoned as this was an easier way to communicate.

Pregnant woman were informed by the midwives to book an appointment for the flu vaccine and where possible the practice nurse immunised them whilst they were visiting the midwife.

Shingles vaccinations were administered separately to flu.

The practice offered basic travel immunisations to its patients but did not offer items not available on the NHS.

Listening and learning from concerns & complaints.

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handles all complaints in the practice.

Complaints were responded in a timely manner and audits were undertaken regularly to review the working procedures and practices which were amended where applicable. The complaints had been analysed to the practice tried to ensure that there were no repeats. The practice manager used the information to create learning points where required and these were fed back to staff for information. Also to support them where processes were correct and followed and any complaint was unfounded.

The practice had a culture of openness and learning. Staff told us that they felt confident in raising issues and concerns. We saw that incidents were reported promptly and analysed. All complaints are discussed the at a Monday lunchtime meeting with the clinical staff, evidence of this was seen in the minutes from the meetings.

The complaints leaflet was available on the reception desk and contained information on referring the complaint to the Parliamentary Ombudsman. Most complaints received this year related to the online system change for booking appointments. This had now been revoked in response to patient concerns.

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 and strategy that placed the quality of patient care as their priority. The practice values and aims were described as being patient centred and providing a caring service to their patients. These were communicated to patients by means of posters in the waiting area and on the practice website. Staff were committed to the practice aims and described the ethos of the practice as being focused on high quality patient care.

Our discussions with nurses and other staff showed that effective communication was a strength for the practice, and that there was a caring ethos of putting patients first that resulted from the GP leadership. Staff told us the practice had an open and equal way of working to ensure that everybody felt part of the team.

Governance Arrangements.

We saw good working relationships amongst staff and an ethos of team working. Partner GPs and the practice nurses had areas of responsibility, such as, prescribing or safeguarding it was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

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

Leadership, openness and transparency.

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We reviewed a number of policies, for example, equality and diversity policy, Complaints handling protocol and recruitment policy in place to support staff. Staff we spoke with knew where to find these policies if required.

The practice had gathered feedback from patients through: patient surveys, comment cards and complaints received.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a new patient participation group and the practice worked with them to help improve the care services. All the patients we spoke with and the comment cards patients had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Management lead through learning & improvement.

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly.

Audit examples seen were, opportunistic infection screening during coil insertions (cycle one, November 2013). Diabetic patients under the age of 55 and how the practice manager to them (cycle one done in 2013, cycle two in 2014 three months after the diabetic review).

Minor surgery and minor operations audit (September 2000 12 August 2013; this is done annually).