Dr Paul Moss

Quality Report

North Shoebury Surgery
Frobisher Way,
Shoeburyness,
Southend on Sea,
Essex,
SS3 8UT
Tel: 01702 297976
Website: www.northshoeburysurgery.nhs.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 Dr Paul Moss Surgery on 01 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), for people whose circumstances may make them vulnerable, and people experiencing poor mental health (including people with dementia).

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

- Staff understood how to report significant events and to raise concerns. We found that action had been taken in response to safety alerts. Actions were also taken following investigations into significant events, and these were reviewed to evaluate their impact.
- Risks to patients were assessed and well administered, with evidence of action planning and learning when needed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with compassion, dignity and respect and the majority said 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 majority of patients said they found it relatively easy to make an appointment with a GP and that there was continuity of care. We were told urgent appointments were available the same day.
- The practice had appropriate facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff told us they felt supported by management.

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on. The practice sought feedback from patients through a patient participation group and a patient survey in relation to the services provided.
- We saw the business continuity plan in action due to the computer patient record system not working when we arrived at the practice. The contingency of working with laptops that had been backed up with the most recent records enabled clinicians to continue working and meant patient care was not compromised during this time.

We saw one area of outstanding practice:

- The practice provided specialist substance misuse treatment, and care for patients. The clinicians had specialist training and reception staff members were trained to support these patients. When the local area service stopped the practice continued to provide this service for their patients. They told us patients had registered at the practice to ensure their access to the substance misuse clinic. By continuing to provide this service to their own patients, continuity of care, with familiar staff members locally was provided. The practice dealt with aspects of substance misuse, in collaboration with the local Community Drug and Alcohol Service (CDAS) to support the patients.

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 learnt 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 members to keep patients safe.

Safety alerts were correctly managed and recorded. Emergency medicines and vaccinations were correctly stored and monitored and the practice was able to respond to medical emergencies. Patients had their treatments and medicines reviewed on a regular basis.

There were arrangements to protect patients from the risk of acquiring infections. There were appropriate staff recruitment procedures in place, and an appropriate number of skilled clinical and non-clinical staff employed to deliver the service consistently. An arrangement was in place for chaperones to be available when required.

Provision was in place to ensure business continuity during periods of fluctuating demand or in the event of an emergency, and staff knew how to access the information to carry out these arrangements.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were 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. Clinical audit was used to inform clinical effectiveness, this included assessing 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 staff.

Clinical practice, including consent and prescribing, was delivered in accordance with nationally recognised best practice in primary care. Internal clinical learning events were held and clinical effectiveness was discussed amongst staff and managed systematically at practice level monthly.

Summary of findings

The practice worked well in partnership with other services to meet the needs of patients. Patients had access to a variety of health promotion information and services that promoted a healthy lifestyle and their health needs were assessed promptly and routinely reviewed.

Are services caring?

Good

The practice is rated as good for providing caring services. The findings from the 2015 national GP survey showed that patients rated the practice higher than other practices in the local area for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. They told us the care was always excellent and staff would ensure they had gone the extra mile when dealing with them. Comments on the cards we had left at the practice for patients opinions described the service as; second to none, cannot fault, and repeatedly we heard, always takes time to listen to patients.

Information for patients about the services available was easy to understand and accessible. We observed staff treated patients with kindness and respect, and maintained confidentiality when greeting them at the practice. For example when a wheelchair user approached the reception desk the staff member came out to the patient in the reception area to speak with them to ensure confidentiality and make eye contact. Another comment we received from a number of people was regarding the excellent support they had received from the practice staff that exceeded their expectations. Patients and carers described the service very positively. Most told us they were given options, available choices, and involved in decisions about their care and treatment.

A healthcare professional at a care home told us that in comparison with other practices in the area the practice was above the rest for service provision, and their communication links. They also praised the reception staff for their understanding and caring attitude.

The practice considered the diverse needs of their patients and action was taken to meet them. We saw evidence that patients were asked for their consent to care prior to treatment.

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and that there was continuity of care. We were told urgent appointments were available

Summary of findings

on the same day they were requested. The practice had adequate facilities and was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff in staff meetings or by internal communication if more urgent.

Staff at a care home provided with GP services from the practice, told us the GP always visited patients if they requested.

Are services well-led?

Good 

The practice is rated as good for being well-led. There was a clear leadership structure and staff told us they felt supported by management.

The practice had a number of policies and procedures to govern activity which we found were regularly reviewed and up to date. The practice held regular clinical and staff meetings to keep staff up to date. There were systems in place to monitor and improve patient outcomes, service quality, and identify risks. 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 marginally above average for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people in its population, and had a range of enhanced services. For example; flu vaccination, avoiding unplanned admissions to hospital, remote care monitoring, and end of life care. An enhanced service is a primary medical service other than an essential service that is in addition to the standard contract for GPs. Staff were responsive to the needs of older people, and offered home visits and longer appointments for those with complex needs. The patients had a named GP to provide consistency during their care and a telephone line had been dedicated for phone calls from this population group.

The practice had regular multidisciplinary team (MDT) meetings where patients at risk of hospital admission who were receiving palliative care and those receiving long term care were discussed. These meetings had minutes and notes written directly into the patient's electronic medical records.

Carers of older people were identified and offered appropriate support. The practice gave 15 minute appointment slots to older people to support their needs. When a patient was frail or had difficulty accessing the practice phlebotomy services, it would be carried out in their home. Phlebotomy is the puncture of a vein in order to draw blood from a patient with a medical needle. Shingles vaccination was offered where indicated.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice nurse had a special interest in chronic obstructive pulmonary disease (COPD) and asthma and saw patients with these conditions on a regular basis. Patients were given a personalised care plan and issued with standby medication to support their conditions during times of deterioration. At the time of our inspection the GP and the nurse were undertaking further training to support patients with diabetes.

Longer appointments and home visits were available when needed. All the patients with long-term conditions 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.

Carers were identified and offered appropriate support. Telephone consultations were provided to people with long term conditions where appropriate.

Patients with long term conditions were discussed during the regular multidisciplinary team (MDT) meetings. The meetings had minutes and notes were written directly onto the patients electronic medical records. The practice offered proactive, personalised care to meet the needs of people with long term conditions in its population, and had a range of enhanced services, for example, to flu vaccinations and remote care monitoring (RCM). RCM is an agreed record of patient preferences for receiving and monitoring their required test results.

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. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had suitable clinical equipment to examine and treat infants and children. High achievement targets for childhood immunisation reflected their values regarding childhood health promotion.

We were told the practice used the 'Spotting the Sick Child' Department of Health initiative to support staff when treating infants and children. This initiative used a consistent methodology to ensure safe working procedures whilst examining and treating children within this population group.

The practice had modified their appointment system after surveying their patients with regards to their preferences when providing extended hours and ease of access for families. The nurse practitioner offered on-the-day minor illness and unscheduled appointments.

The practice worked closely with the local maternity services to fully support and work alongside the midwives to provide post-natal care. There were regular multi-disciplinary meetings at the practice,

a health visitor and a school nurse regularly attended, the topics discussed included safeguarding issues. We saw examples of joint working with midwives, health visitors and school nurses within meeting minutes.

In addition to GP consultations the nurses provided clinics for family planning, menopause advice, maternity services, health promotion and child health. Data we viewed collected in 2013 – 2014 showed the uptake for cervical cytology of eligible women aged 24-65 was above the national average. Information about Chlamydia screening was posted in the waiting room and in the patient toilets to promote awareness.

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 reflected the needs for this population group.

The practice offered NHS health checks for patients in this population group that were generally well and had not visited the practice in the last year or more.

The practice had committed to an enhanced service for extended hours this meant the practice aimed to enable patients to consult a health care professional, face to face, by telephone or by other means at times other than during core practice opening hours. An Enhanced Service is a primary medical service other than an essential service that is in addition to the standard contract for GPs. They also offered website on-line bookable appointments and on-line repeat prescription requests to reduce the need to access the practice in person. Access for students studying away from home was available.

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, travellers, asylum seekers and those with a learning disability. The practice identified and registered patients aged 14 and over because of their learning disabilities and we saw they provided all patients

on the register with an annual health check. The practice told us they did not rely solely on these annual health checks and saw patients more regularly in response to their needs. The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. These meetings incorporated a health visitor, and a school nurse, topics on the agenda included safeguarding issues. The practice used a flagging system which alerted staff members to the needs of vulnerable patients. They had told vulnerable patients how to access various support groups and voluntary organisations. The practice worked with other professionals to safeguard patients for example safeguarding forums and training sessions.

Staff knew how to recognise the signs of abuse in vulnerable adults, children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact to raise concerns. A GP at the practice was the safeguarding lead with oversight regarding local area issues.

The GP and nurse practitioner had been trained in substance misuse. The practice dealt with aspects of substance misuse, in collaboration with the local Community Drug and Alcohol Service (CDAS) to support patients, as there was no locally commissioned service. In addition they supported high risk alcohol users where there was a low severity of withdrawal. This service benefitted the patients that had registered with the practice to access this service and were provided continuity of care with familiar clinicians.

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). Everybody experiencing poor mental health, on the practice register, had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had provided information and told patients experiencing poor mental health how to access various support groups and voluntary organisations. Staff had received training to support and communicate with people that had mental health needs and dementia. The practice had a counsellor from the 'Therapy for You' service that attended the practice weekly. This was part of the Improving Access to Psychological Therapies (IAPT) initiative the practice was involved with.

Summary of findings

The practice had been in a pilot for 'Improving physical health in those suffering with severe mental illness' initiative and after the pilot finished continued with this consistent monitoring during regular physical check-ups for patients in this population group. The practice had also reviewed newly registered patients aged 16 and over, and where identified as possibly drinking alcohol at increasing risk or higher risk levels, offered and delivered a brief treatment to reduce alcohol related health risks.

Longer appointments were available to these patients. The local GP Mental Health Crisis Line was also used by the practice to provide further support for this population group.

Summary of findings

What people who use the service say

We spoke with four patients during the inspection, and they told us they were happy with the service provided at the practice. Patients told us that they could obtain an emergency appointment, on the same day they requested one. All patients we spoke with told us they were treated with dignity and respect by all clinicians and non-clinical staff members. Patients described the practice as clean and tidy when we asked their opinion of the practice environment.

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 14 cards that had been left for us and reviewed the comments made. Patients who completed cards were positive about the care they received at the practice. There were 12 cards with comments that were extremely positive about the staff, most referred to both their kindness and helpfulness. Some of those who completed cards reported that they felt they were listened to and involved in decisions about their care. They also said the care was always excellent and staff would ensure they had gone the extra mile when dealing with them. There were two less positive comments but each of these had unrelated issues with no trends.

A healthcare professional at a care home told us that the GP always came if they asked for a visit, which helped them to provide good care for their patients. They said that in comparison with other practices in the area the practice was above the rest for service provision, and their communication links. They also gave us positive comments with regards visiting the practice with patients and receiving prescriptions.

Staff at a local pharmacy spoke highly of the GP commenting they had a really good rapport and communicated regularly to sort out any queries. The pharmacy had a direct number through to the GP in order to resolve any issues quickly. They also indicated the practice had been receptive to changes in pharmacy processes to improve the service to patients.

A local community healthcare professional told us they had excellent communication links with the practice. They told us they were provided with the appropriate and sufficient information to carry out their role.

Outstanding practice

The practice provided specialist substance misuse treatment, and care for patients. The clinicians had specialist training and reception staff members were trained to support these patients. When the local service stopped the practice continued to provide this service for their patients. They told us patients had registered at the practice to ensure their access to the substance misuse clinic. By continuing to provide this service to their own patients, continuity of care, with familiar staff members locally was provided. The practice dealt with aspects of substance misuse, in collaboration with the local Community Drug and Alcohol Service (CDAS) to support the patients.

Dr Paul Moss

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Lead Inspector who was accompanied by a Care Quality Commission GP specialist advisor.

Background to Dr Paul Moss

Dr Paul Moss, North Shoebury Surgery is a single handed practice supported by a regular part-time locum GPs. The practice serves approximately 3,541 people who live in Shoeburyness. The practice holds a general medical service (GMS) contract to provide their services.

The GP is male and regular locums are male and female. The GPs are supported by two nurses, a healthcare assistant, a team of five administrative assistants/ secretaries/reception staff and a practice manager.

The practice opening hours are from 8.30am to 1pm each day and from 2.30pm to 7pm Monday, Wednesday, and Friday, from 2.30pm and from 2.30pm to 8.00pm on Tuesdays and Thursdays. Surgery hours are from 9.00am to 12.00noon each day and from 4pm to 6pm on Monday and Friday, from 4.00pm to 7.30pm Tuesday, from 2.30pm till 6.00pm on Wednesday and from 5.30pm to 7.50pm on Thursday.

The practice provided extended hours on Tuesday and Thursday evenings. This surgery was for routine pre-booked appointments only.

The practice nurses held various clinics from Monday to Friday between 9am and 5pm.

The practice has opted out of providing 'out of hours' services which is provided by Care UK. Patients can also contact the NHS 111 service to obtain medical advice if necessary.

Why we carried out this inspection

We inspected Dr Paul Moss at North Shoebury Surgery as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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?

Detailed findings

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

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

For example:

Before visiting, we reviewed a range of information that we hold about the practice and asked three healthcare professionals to share what they knew. We carried out an announced inspection on 01July 2015. During our visit we spoke with a range of staff these included GPs, nurses, the practice manager, receptionists, secretaries and the prescription clerk. We also spoke with four patients visiting the practice on the day of inspection that used the service. We observed how people were being cared for and talked with and reviewed the practice policies and procedures. We reviewed comment cards where patients and members of the public had shared their views and experiences of the service, surveys and audits.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. We were shown that at clinical meetings, safety alerts were reviewed for example National Patient Safety Alerts (NPSA), and Medicines and Healthcare Regulatory Authority (MHRA) alerts. The practice manager explained the procedure to deal with alerts at the practice and we were assured that these had been actioned and dealt with appropriately.

Staff knew how to report significant events, and records seen showed events were reported appropriately. We saw significant events were a standing agenda item at clinical staff meetings, when we spoke with staff they confirmed events were shared and discussed with them.

The annual review of safety incidents showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

Safety records and incident reports followed root cause analysis (RCA). RCA is the recognition and assessment of the reason an incident of an undesirable nature occurred, and the analysis to rectify or prevent future occurrence, showing lessons learned. Incident records seen were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning from incidents had been shared. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated to the appropriate staff members. Staff we spoke with also told us alerts were discussed at clinical and staff meetings to ensure all staff were aware of any that were relevant to the practice and where action was needed. The practice manager recorded the alerts received and actioned by the practice.

Reliable safety systems and processes including safeguarding

The practice had a system to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibility with regards information sharing, how to properly record and document safeguarding concerns and who to contact.

The practice had appointed a dedicated GP as their lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil this role. All staff we spoke with knew who the lead was and who to speak to within the practice if they had a safeguarding concern.

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. The practice manager told us there was effective practice engagement regarding local safeguarding procedures and valuable working relationships with relevant organisations, these included health visitors, local care staff, and the local authority.

There was information for patients about requesting a chaperone in the waiting area. (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). The practice chaperone policy had been regularly reviewed and was up to date. Only the nursing staff were asked to chaperone patients during examinations and understood their role when chaperoning.

We found information regarding abuse and avoidable harm displayed in both the waiting area and patient toilet for those not wanting to disclose details to staff About an incident.

Medicines management

We checked the medicines used for patient treatment and found they were stored securely. There was a policy to ensure medicine that was kept in the fridge remained at the required temperature, with a description of the action to take in the event of a potential failure. Records showed fridge temperatures were checked and medicine was

stored at the appropriate temperature. There were processes in place to check medicines were within their expiry date and suitable for use. All medicine we checked was within the expiry dates and suitable for use.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription pads for hand written prescriptions and prescription forms for use in the printers were handled in accordance with national guidance, tracked through the practice, and kept securely at all times.

The practice provided us with their procedure to manage high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which requires patients to have regular blood monitoring in accordance with national guidance. We saw that appropriate action had taken based on patients results, and where patients care was shared by the hospital this was recorded and kept up to date on patient's records.

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. PGDs are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. We saw the PGDs used by the nursing staff had been reviewed and updated this year.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection prevention and control policy. This included infection control procedures, the management of needle-stick injuries and clinical waste management. The policy gave guidance to staff regarding, personal protective equipment, disposable gloves, aprons and coverings that we saw were available for staff to use. An infection control audit had been undertaken on an annual basis in line with their policy, and any actions required were undertaken in response to the audit. The practice had a nurse who was the lead for infection prevention and control issues. This nurse had received infection prevention and control training and was due to attend further training in the next two months. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and paper hand towel were available in treatment rooms.

We saw there were cleaning schedules in place and cleaning records were kept. The cleanliness of the treatment rooms were checked and records kept. The hand gels available on the day of our inspection were in date, and kits for bodily fluid spillages were available. The curtains in the consultation and treatment rooms were clean. A waste management contract was in place and the practice policy and procedure met the national primary care guidance.

A legionella risk assessment was seen and we saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings and can be harmful.)

Equipment

A clinical staff member told us they had sufficient and adequate equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records showed that there were effective arrangements in place to check, service and recalibrate all clinical equipment, supported by an up to date protocol. Medical screening equipment was recalibrated in accordance with manufacturers' instructions, and records supported these arrangements. We also saw portable electrical equipment displayed stickers indicating that these had been tested for electrical safety.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at four staff files and they contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Good

Are services safe?

We saw evidence to show there were arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were told there was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and newly appointed staff had this expectation written in their contracts.

Staff members told us there were normally enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

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, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy, health and safety information was displayed for staff to see, and there was an identified health and safety lead staff member.

When identified, any risks were added to a risk log and assessed and actions recorded to reduce and manage it. We saw examples of this such as dealing with the risk of rain puddles.

There were monitoring systems in place for patients with long-term conditions. Staff members told us referrals were made for patients whose health had deteriorated suddenly and explained how a summary of their care was sent with the patient to ensure healthcare professionals had current and up to date information to treat them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED). An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm. When we asked members of staff, they knew the location of this emergency equipment and records confirmed that it was checked regularly to ensure it was suitable for use.

Emergency medicines were accessible to staff in a clinical area of the practice and staff knew the location. These included medicine for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Anaphylaxis is a sudden allergic reaction and hypoglycaemia, or low blood sugar, is a common problem in people with diabetes. Processes were also in place to check whether emergency medicines were within their expiry dates and suitable for use. 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 may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to access. For example, private contact details of practice management staff and the lead GP. The plan was available to staff and last reviewed in 2015. During our inspection we saw the plan in action. The computer patient record system not working when we arrived at the practice. The contingency of working with laptops that had backed up with the most recent records enabled clinicians to continue working and meant patient care was not compromised during this time.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff had attended fire training and that they had practised fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with 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 how they accessed these from icons on their computers. Staff we spoke with demonstrated a good level of understanding and knowledge in regard to NICE guidance and local guidelines. The practice manager told us updates and new information from NICE was discussed at monthly clinical meetings confirmed in meeting minutes.

Staff explained how care was planned to meet identified patient needs. Patients were reviewed six monthly to ensure their treatment remained effective, for example, patients with diabetes had regular health checks and were being referred to other services when required.

The GP told us they led in clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD) and child protection, and that practice nursing staff supported this work. COPD is a severe shortness of breath caused by persistent lung disease. They also explained they were a professional member of Diabetes UK and at the time of our inspection carrying out an audit of patients with diabetes to identify those at increased cardiovascular risk.

The practice used computerised tools to identify patients who were at high risk of admission to hospital as part of the admission avoidance work they were involved with. The practice monitored the accident and emergency discharges they received that comprised all population groups at the practice monitored unplanned admissions to hospital for all its population groups. This work included developing a written and electronic personalised care plan collaboratively with the patient and their carer (if applicable).The care plan was jointly owned by the patient, carer (if applicable) and named accountable GP. These patients were reviewed regularly to ensure the multidisciplinary care plans were documented in their records and their needs were being met, to assist in reducing the need for them to go into hospital. Patient's electronic records showed that multidisciplinary meeting decisions were recorded and acted on. We were told when high risk patients were discharged from hospital they were followed up to ensure their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. We were told the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. This formed part of the statement of purpose for the practice.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then used to support the practice to carry out clinical and administrative audits.

The practice showed us two clinical audits that had been undertaken in the last year. Both of these were in the process of being re-run to check the changes resulting since the initial audit. For example all clinicians at the practice changed their prescribing habits for urinary tract infections and chest infections with antibiotics. When they reviewed patient outcomes after the initial audit they concluded greater adherence to the guidelines was needed. Initial findings showed that adherence to guidelines were providing improved outcomes for patients.

We saw audit records documenting the actions taken in response to neuropathic pain medicine prescribing data. This was undertaken to ascertain the need to prescribe the drug appropriately to ensure the risks of dependence and misuse were at a minimum and regularly reviewed. The results showed prescribing against guidelines had improved by reviewing patients taking this medicine. Following the review only 31 of the 53 patients continued to take the original medicine prescribed.

The GPs told us clinical audits were often linked to 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

Good

Are services effective?

(for example, treatment is effective)

implementation of preventative measures. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 97.1% of the total QOF target in 2014, which was 3% above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was 9.2 percentage points above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was 11.6 percentage points above the national average.
- Performance for mental health related and hypertension QOF indicators were 9.6 percentage points above the national average.
- The dementia diagnosis rate was 6.6 percentage points above the national average and 13.6 percentage points above the local Clinical Commissioning Group (CCG) average. A CCG is a group of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The clinical staff we spoke with told us how in their clinical meetings they discussed and reflected on the outcomes being achieved and areas where improvement could be made. Staff members; spoke positively about the practice approach to audit and service quality improvement.

The practice's prescribing rates were similar to national figures and any medicines that had been outside the normal range had been audited to ascertain the reason. There was a policy 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 GP was prescribing medicines.

The practice had a palliative care register and had regular internal and multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example travellers, and learning disabilities. Structured annual reviews were also undertaken for people with long term conditions for example diabetes, chronic obstructive pulmonary disease (COPD), and heart failure.

The practice manager explained that priority for appointments was given to babies and children, the over 75's and those with an emergency need. Late evening appointments were also available twice a week to improve access for school aged children and those patients that needed an appointment outside working hours. We also saw the practice offered a wide range of clinics and special healthcare services in addition to GP and nurse consultations, for example: health promotion, diabetic management, family planning and alcohol/drug abuse consultations.

Effective staffing

The practice staffing included medical, nursing, managerial and administrative staff. We reviewed three sets of staff training records and saw that staff members had attended role related training courses and all staff had attended annual basic life support. We found training was a standing agenda item for practice meetings.

The GP was up to date with their yearly continuing professional development requirements and had a date for revalidation in September 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had undertaken an annual appraisal that identified learning needs from which action plans were documented. During interviews with staff members they confirmed that the practice was proactive in providing training and funding for relevant courses, for example infection control training, smart card training, and health and safety.

Practice nursing staff had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, in the administration of vaccines, cervical cytology, and dressings.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

Good

Are services effective?

(for example, treatment is effective)

The practice had a procedure outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and acted on the day of receipt. The GP who saw these documents and results was responsible for the action required. Staff we spoke with identified the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice held bi-monthly multidisciplinary team meetings to discuss patients with complex needs, those who were frail or elderly, and patients who had attended accident and emergency or had contact with the out of hours service. These meetings were attended by a district nurse, and an end of life health professional. Staff reported that these arrangements for multi-disciplinary working were effective and worked well. We were told by a member of the district nursing team that the practice always asked for a representative to attend these meetings. The practice manager also attended regular meetings with practice managers in the area to share information and to learn about local issues.

The practice told us about the close working relationship they had with the medicines management team to carry out regular audits to deliver cost effective, and patient improved outcome prescribing.

Emergency hospital admission rates for the practice were as expected in comparison with the national average. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings bi-monthly to discuss patients with complex needs. For example, those with multiple long term conditions, learning disciplinary problems, and those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and were shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. There was a system for sharing appropriate information for patients with complex needs to the ambulance and out-of-hours services. Information from the out-of-hours service provider was checked on a daily basis and flagged to the GP for them to action.

For patients who were referred to hospital in an emergency there was a procedure to provide a printed copy of a summary record for the patient to take with them and a hand written letter to the hospital or Accident and Emergency (A&E). The practice had a computer medical record system and access to computer based policies, procedures and protocols to provide staff with the information they needed. Staff used the computer medical record system to coordinate, document and manage patients' care. All staff were fully trained on the system which 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 them. Staff were also familiar with Gillick competencies. (Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.) We found the clinical staff we spoke with understood the key parts of the legislation and were able to describe, using the different situations they had encountered, and how it was

Implemented it their practice.

The nursing staff we spoke with were aware of the arrangements for gaining parental consent before issuing a vaccine. They were clear that childhood vaccinations would not be given if the child were brought in by a person other than the parent. The nursing staff were aware of obtaining informed consent from patients. They told us they would describe the examination or treatment to the patient in advance and obtain consent before proceeding. We saw

Good

Are services effective?

(for example, treatment is effective)

evidence of consent given by patients for cervical screening for example. The GP showed us the request for written consent for patients prior to minor surgery, and how this was recorded on patients' notes.

The practice policy described how patients with a learning disability or 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.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice offered a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. 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 opportunistic life style advice and smoking cessation advice to smokers.

The practice had many ways of identifying patients who needed additional support, and was pro-active in offering additional help. For example, the practice had identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. The practice's success rate for smoking cessation was 98%, which was 4.3% above the national average of 93.7%. Similar mechanisms of identifying 'at risk' groups were used for patients who needed dietary advice and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 98.26 %, which was 3% above the national average of 95.29 %. 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 well above the national average and in many cases 100%.

Patients had access to a range of information to support them to achieve and maintain healthy lifestyles. Written information was available at the practice, and on the practice website about common medical conditions, support agencies, immunisations and other health promotion issues. Posters displayed within the waiting area informed patients of the range of health and social care services and screening available that may meet their current needs. Further health promotion information was included in the practice leaflet.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw patients were treated with dignity and respect by staff when being greeted by reception staff and when answering and dealing with patient enquiries. There was information available in the waiting room telling patients they could ask to speak with staff in privacy. We saw how staff observed patient confidentiality by discussing matters quietly and sensitively to reduce the risk of being overheard. Staff checked patients' identity by using their dates of birth rather than their name.

Before our inspection we left comment cards for patients to complete to give their views on the practice. We received 14 completed comment cards. There were 12 very positive cards revealing information about their excellent treatment by staff and describing staff as friendly, respectful and helpful. Two cards were less positive; these were unrelated and showed no similar theme.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey published on 4 July 2015.

The evidence from these sources showed patients were satisfied with the manner they were treated with compassion, dignity and respect. For example, data from the national GP patient survey 2015 showed:

- 95% of patients found the receptionists at this surgery helpful. In comparison with 83.9% in the CCG area and 86.9%nationally.
- 97.1% of patients had confidence and trust in the last nurse they saw or spoke to. In comparison with 97.2% in the CCG area and 97.2% nationally.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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.

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.

A healthcare professional involved with the care of elderly and vulnerable adults in a care home said the GP always came to visit patients if they asked. Referrals were dealt with swiftly, transport was arranged when patients had hospital treatment and the practice dealt with medicine and changes to medicine and prescriptions in a timely manner. They also praised the reception staff for their understanding and caring attitude, and said that in comparison with other practices in the area the practice was above the rest for service provision, and their communication links.

Care planning and involvement in decisions about care and treatment

The GP national patient survey information showed patients were positive to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice similar to other practices in these areas. For example:

- 91.5% of patients who responded said the last GP they saw was good at explaining tests and treatments. In comparison with 80.8% in the CCG area and 86.3% nationally.
- 85.7% of patients who responded said the last GP they saw was good at involving them in decisions about their care. In comparison with 78.1% in the CCG area and 81.5% nationally.

Patients we spoke with during the day of our inspection told us they felt involved in making decisions about their care and treatment they received. They also told us they felt listened to and supported by staff, and clinicians gave them sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was extremely positive and aligned with these views.

Staff told us that translation services such as the "Big Word" were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

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

- 86.5% of patients who responded said the last GP they spoke to was good at treating them with care and concern. In comparison with 81.5% in the CCG area and 81.5% nationally.
- 89.3% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared. In comparison with 90.3% in the CCG area and 90.4% nationally.

The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this survey information. For example, they highlighted that clinical staff responded to them with care and compassion when they needed help and support.

Notices in the patient waiting room, in the practice leaflet and the patient website also told patients how to access a number of helpful support groups and organisations. The practice's computer system alerted all staff members if a patient was also a carer. We were shown the written information that was available for carers to ensure they understood the various organisations that could provide support that was available to them.

Staff told us that if families had suffered bereavement, the GP contacted them personally when appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice manager shared with us the evaluation of the practice needs to ensure there was sufficient staff numbers and the correct skill mix to keep patients safe.

The practice attended peer review meetings with the clinical commission group (CCG) to discuss the proposals and share information about the needs of the practice population identified in local public health information. A CCG is a group of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The public health and CCG information was used to help focus services offered by the practice.

When a provider stopped delivering a substance misuse clinic within the practice premises the practice continued to provide this service to their own patients. They told us patients had registered with the practice to ensure they could have access to the substance misuse clinic. By continuing to provide this service to their own patients, continuity of care, with staff members they have built up a rapport, was provided. The GP and nurse practitioner had part two certification in 'Substance Misuse'. The nurse practitioner also had experience of prison medicine. The practice dealt with aspects of substance misuse, such as benzodiazepine misuse, in collaboration with the local Community Drug and Alcohol Service (CDAS) to support their patients, as there was no locally commissioned service. In addition they supported high risk alcohol users where there was a low severity of withdrawal.

There was no active patient participation group (PPG) although the practice had recently sent out invites to patients to set up a group. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. For example, there were longer appointment times available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. The majority of the practice population was English speaking patients but access to online translation services using the 'Big Word' was available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as the service was provided all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. There was sufficient space within the waiting room for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The practice told us they would register patients as temporary residents if necessary to ensure they could access medical services for example where a person may have no fixed abode.

There was access to a male and female locum GPs in the practice providing patients with choice.

Access to the service

The practice opening hours are from 8.30am to 1pm each day and from 2.30pm to 7pm Monday, Wednesday, and Friday, from 2.30pm and from 2.30pm to 8.00pm on Tuesdays and Thursdays. Surgery hours are from 9.00am to 12.00noon each day and from 4pm to 6pm on Monday and Friday, from 4.00pm to 7.30pm Tuesday, from 2.30pm till 6.00pm on Wednesday and from 5.30pm to 7.50pm on Thursday.

The practice provided extended hours on Tuesday and Thursday evenings. This surgery was for routine pre-booked appointments only. The practice nurses held various clinics from Monday to Friday between 9am and 5pm.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to book urgent and routine appointments, home visits, and order repeat prescriptions 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 regarding the out-of-hours

Good

Are services responsive to people's needs?

(for example, to feedback?)

service was also provided to patients via the practice leaflet and website. The practice had opted out of providing 'out of hours' services which was provided by Care UK. Patients could also contact the NHS 111 service to obtain medical advice when necessary.

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

- 75.7% of patients who responded were satisfied with the practice's opening hours. In comparison with 75.1% in the CCG area and 75.7% nationally.
- 70.4% of patients who responded described their experience of making an appointment as good. In comparison with 70.8% in the CCG area and 73.8% nationally.
- 52.9% of patients who responded said they usually waited 15 minutes or less after their appointment time. In comparison with 68% in the CCG area and 65.2%nationally.

Patients we spoke with were satisfied with the appointments system and said they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also 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 to handle complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager within the policy was the designated responsible person who handled all complaints at the practice.

We saw there was information available to help patients understand the practice complaints system. Information was displayed in the waiting room; there was information on the practice leaflet, and on the practice website. 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.

We looked at seven complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and noted there were no themes identified. However, lessons learned from individual complaints had been discussed at practice meetings and acted on with improvements made as a result.

We saw there was a comment, suggestions and compliments box available and easily accessible for patients. The staff members we spoke with told us the practice manager had an open door policy for them.

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. We found details of the vision and practice values were part of the practice's statement of purpose publicised on the practice website. The practice vision and values reflected the practice aim to provide quality care, working in partnership with patients and to ensure staff were motivated and competent to carry out their role.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of computers within the practice. We looked at 20 of these policies and procedures and all those we looked at had either been recently reviewed or were due to be updated soon.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and a GP lead for safeguarding. We spoke with members of staff and found they understood their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns they may have.

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 monitored and were effective. This 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 in line with national standards.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the primary care safeguarding standards audit, a flu uptake audit, smear audit, and an antibiotic audit. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and improvements had been implemented.

Staff members told us during monthly staff meetings governance, performance, and quality and risks issues were discussed. We saw meeting minutes that confirmed these topics had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies within the staff information, for example disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the electronic staff policies that were 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 electronically on the computer if required. They also told us they had been given a copy of these policies to take home.

Leadership, openness and transparency

The senior GP was visible in the practice and staff told us that he was approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and given the opportunity and encouraged to express ideas regarding how to develop the practice.

We saw that staff meetings were held monthly. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at staff team meetings and were confident and felt supported if they did. Staff told us they felt respected, valued and supported, particularly by the GP and practice manager at the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the 'Friends and Family test' FFT which showed the 51 responses received between January and June 2015 were all likely or extremely likely to recommend the practice. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received

Are services well-led?

Good

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

to friends and family who need similar treatment or care. The practice held ad hoc surveys to understand specific aspects of practice service delivery, for example learning disabilities (LD) checks survey and extended hours survey. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice by inviting patients to be involved with a patient participation group.

The practice had also gathered feedback from staff through staff meetings, appraisals and ad hoc discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very facilitative of training to support their role development.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice learned from these and improved outcomes for patients.