Drs Harris, Hughes, Pearce, Trenholm and Tresidder

Quality Report

Summerfields Road
Chard
Somerset
TA20 2EW
Tel: 01460 63380
Website: www.springmeadsurgery.co.uk.

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Drs Harris, Hughes, Pearce, Trenholm and Tresidder (Known as Springmead Surgery) was inspected on Wednesday 12 November 2014. This was a comprehensive inspection.

Springmead Surgery provides a service to approximately 6,500 patients in the Somerset town of Chard. The practice provides primary medical services to a diverse population age group.

The team at Springmead is composed of five GP partners. GP partners hold managerial and financial responsibility for running the business. In addition there were three registered nurses, two health care assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

We rated this practice as good.

Our key findings were as follows:

There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who used the service. Significant events were recorded and shared with multi professional agencies. There was evidence that lessons were learned and systems changed so that patient care is improved.

There were systems in place to support the GPs and other clinical staff to improve clinical outcomes for patients. According to data from the Quality and Outcomes Framework (QOF), outcomes for patients registered with this practice were equal to or above average for the locality. QOF is the annual reward and incentive programme detailing GP practice achievement results, Patient care and treatment was considered in line with best practice national guidelines and staff were proactive in promoting good health.

The practice were pro-active in obtaining as much information as possible about their patients which affect

Summary of findings

health and wellbeing. Staff knew the practice patients well, were able to identify people in crisis and were professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. There were good facilities available. Adjustments were made to meet the needs of the patients and there was an improving appointment system in place which enabled good access to the service.

The practice had a clear vision and set of values which were understood by staff and made known to patients. There was a clear leadership structure in place. The team structure had changed in recent months with the introduction of new practice manager and nursing team.

Many of the issues we identified had already been recognised and were being addressed to make sure quality and performance was monitored and risks are identified and managed.

There were also areas of practice where the provider should make improvements.

The provider should ensure that:

- All clinical staff receive training in the Mental Capacity Act (2005).
- Policies and procedures should be kept up to date and made available to all staff.
- A health and safety audit should be repeated and action points from it taken forward.

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 safety.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent. Risk assessments were performed when a decision had been made not to perform a criminal records check on administration staff.

Significant events and incidents were investigated systematically and formally. There was a culture to ensure that learning and actions had been taken and communicated following such investigations, and staff confirmed their awareness. The GPs were in the process of extending this to the wider team rather than just clinical staff.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005 (MCA). MCA training had been provided for GPs. However, not all staff had received this. There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management of medicines within the practice.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as good for effective.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both national institute for health and care excellence (NICE) guidelines and other locally agreed guidelines. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients.

Summary of findings

The practice had opted out of the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme but provided data to show that the practice is performing equally when compared to neighbouring practices in the Clinical Commissioning Group (CCG).

People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate and in addition to their roles. Effective multidisciplinary working was evidenced.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes.

There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff.

The practice worked together efficiently with other services to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for caring.

Feedback from patients about their care and treatment was consistently positive. Data reflected this feedback.

We observed a person centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Accessible information was provided to help patients understand the care available to them.

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

We found the practice had responded to patient feedback following the introduction of a change in appointment system. The practice recognised this had been introduced with minimal patient consultation but had subsequently changed the way patients could

Summary of findings

access appointments. For example, patients expressed dissatisfaction that they could not book routine appointments in advance. This was changed and the practice were looking at ways they could obtain further feedback from patients.

The practice was supported by an active and diverse Patient Participation Group (PPG). The practice and PPG had responded to a request from the leadership team about the appointment system and had been involved carrying out a survey.

Patients said they could get an appointment with a GP on the same day.

The practice reviewed secure service improvements where these were identified. For example, a scheme to prevent unnecessary hospital admissions.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for well led.

The practice is rated as good for being well-led. It had a clear vision and strategy. There had been changes to the management and nursing team in recent months. The new team had identified where improvements were needed and were already beginning to address these.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures to govern activity. However, some of these were in the process of being updated. There were systems in place to monitor and improve quality and identify risk. The process of clinical governance was being improved with the introduction of whole team meetings to discuss significant events so learning could be shared with the whole team.

The practice learnt from past events where patient views were not sought as a routine. Feedback is now sought from staff and patients, which is acted on. The patient participation group (PPG) was active. 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's patient population had a relatively higher proportion of older people compared to the county and the England Average.

Patients aged 75 and over at the practice had their own allocated GP, although they did have the choice to see any of the GPs.

There was a system for out of hour's providers to access some clinical and social information for those patients who had complex needs.

The GP and Practice Nursing team promote information on the prevention and management of long term conditions. The practice had introduced an "over 75's clinic" held for patients not seen by a GP for 3 years.

The practice had a system to identify older patients who required a co-ordinated multi-disciplinary care plan. The practice communicated with the multi-disciplinary team (community nurses, community matrons, independent living team, and specialist community palliative care nurse) to discuss palliative, end of life patients and support mechanisms for vulnerable patients.

All patients eligible for the flu, pneumococcal and shingles vaccines had been invited to attend clinics. Housebound patients were being visited and vaccinated by the practice nurse.

The Practice was on one level for easy access. The internal entrance doors automatically open by pushing a button to assist people with mobility issues or those pushing prams and wheelchairs.

The patient participation group (PPG) included representation from the older patient group from the practice.

Springmead is named as a lead GP practice on a complex care role in the local federation. This provided patients in specific residential care homes with an increased level of GP assessment management and escalation planning. It also provided important experiences for GP Trainees.

GPs attend additional training in care of older people and shared learning with practice colleagues.

The practice worked hard to prevent unnecessary and avoidable admissions to hospital, and worked closely with other health professionals both in the community and secondary care. The practice worked with patients to help avoid unplanned hospital admissions by sharing information with Somerset urgent care

Summary of findings

service and ambulance services to inform them of any out of hours care the patients may require. Selected patients have rapid telephone access with clinicians at the practice via a designated phone line. The administration team viewed all hospital discharge summaries to ensure patients on the register had relevant follow up within three days.

People with long term conditions

Good

The practice had systems in place to identify patients who may be vulnerable, have multiple or specific complex or long term needs.

Home visits and medication reviews were offered to all patients with long term conditions who had recently been discharged from hospital. The GPs also have protected time for home visits to housebound patients with long-term conditions.

Patients with long term conditions were invited into the surgery for regular consultations and medication reviews, vaccines and additional screening as necessary. The practice used flu vaccination clinics to offer patients with long term conditions screening to detect diabetes and atrial fibrillation.

The GPs and practice nursing team promoted the effective management of a long term conditions that a patient may have. Patients with long term conditions have tailor made care plans in place.

In situations where a patient is nearing end of life the practice operates a system where 'just in case bags' were located in a patients home environment to assist with the medicines management of their symptoms.

The practice worked with external health care professionals to ensure advice and guidance was obtained as required. Regular meetings with the community matron took place to review patients with long term conditions who were at particular risk of exacerbations and/or emergency hospital admission.

The GPs currently managed long term diseases including diabetes, asthma and chronic obstructive pulmonary disease (COPD). Personalised management plans were developed with the patient.

The GPs have worked with all three of Chard's pharmacies to improve cooperation and communication of prescribing and dispensing of medicines for patients with long term conditions.

The GPs also worked with other practices and provided 24hour ambulatory electrocardiogram (ECG- heart monitoring) services for all Chard GP practices.

Summary of findings

The GP and/or Practice Nurse attend training and education sessions to ensure treatment was in line with national guidelines. The new nursing team had an increased range of skills and knowledge in long term conditions. The practice held education afternoons for the whole practice team on how they can improve care for patients with long term conditions.

The practice promoted independence and encouraged self-care for this patient group. For example, there was a blood pressure machine in the waiting area so patients could monitor their own blood pressure. The practice use 'Telehealth' to support selected patients with long term conditions to monitor their health. Telehealth is the remote exchange of data between a patient at home and their clinician(s) to assist in diagnosis and monitoring. Among other things it comprises of fixed or mobile home units to measure and monitor temperatures, blood pressure and other vital signs parameters which may instigate early intervention of any deterioration.

Health education around diet and lifestyle was promoted by all GPs and practice nurses. Patients were encouraged to enrol on a weight management or smoking cessation programme where appropriate. The practice had a medical library where patients could borrow books on long term conditions and health related matters.

The practice identifies patients who were carers and offered support and health care checks.

Families, children and young people

Good

Women and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. Men were also able to get contraceptive advice, basic sexual health screening and chlamydia testing.

The practice promoted and offered a chlamydia screening programme specifically for young people.

Patients were able to book a telephone consultation on the same day and would be triaged by a GP to decide whether the parent/guardian requests a face to face appointment or the issue could be managed by a telephone consultation.

Ante-natal care was provided by a visiting midwife and the GPs where appropriate. A weekly ante natal clinic took place at the practice so midwives could discuss any concerns with the GP at any time. A private area could be provided for breast feeding mothers.

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The GPs carried out child health surveillance and post natal checks. One of the GPs is experienced in taking blood from children, thus avoiding the child having to go to hospital.

The practice offered the full range of vaccinations as per the current NHS schedule. The practice invited parents and guardians to these appointments. These were carried out during routine weekly appointments.

The practice worked with the health visitor and was able to access support from children's workers and parenting support groups where relevant. Continuing monthly meeting with health visitors were held to discuss vulnerable and at risk families and children.

Systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

There is a dedicated children's section of the waiting room with toys. These are cleaned regularly and a record for audit is maintained.

The practice used any incident, safeguarding or complaint involving a child as an opportunity to review, reflect and re-evaluate the care provided. GPs had attended study days in the care of children and young people.

The practice had a medical library where patients can borrow books on parenting and family health.

Working age people (including those recently retired and students)

Good

Evening appointments were available with a GP and nurse one day a week to help those patients who worked during normal office hours. Patients were able to use the telephone consultation service if more convenient.

Patients could request repeat medications via e mail, the local pharmacy or in person at the health centre. These were usually processed within 24 hours and scripts could be collected from the health centre, pharmacy or sent by post.

Travel advice including up-to-date vaccinations and anti-malarial drugs were available from the practice.

Patients between the ages of 45 and 74 were invited to a well-being health check. 58% of patients had taken up this offer. For the other patients, staff offer opportunistic health checks on patients as they attend the practice. This included offering referrals for smoking cessation, providing health information, routine health checks including blood tests as appropriate, and reminders to have medication reviews.

Summary of findings

Patients were encouraged to enrol on a weight management programme as appropriate. The practice offered referrals to the local gym to help support lifestyle change and weight loss.

The practice had a Patient Participation Group (PPG) which included people of working age. Patients were invited to join on registration and membership was promoted through the patient newsletter and on the waiting room screen. The PPG initiated the latest patient survey.

The practice had a detailed website which patients who were unable to access the practice during office hours could use. This included information about opening hours, clinics available and the others services the practice offered. Patients could use this to request repeat prescriptions, update their contact details and basis clinical information (blood pressure, weight, etc.)

People whose circumstances may make them vulnerable

Good

The practice had a vulnerable patient register and systems in place to identify vulnerable patients who may not be able to access primary medical care.

The GPs referred vulnerable patients to the community matron who then visited, assessed and reported back to GPs who then, with the multidisciplinary team, facilitated any support that was required.

Patients with learning disabilities were offered a health check every year during where their care needs were discussed with the patient and their carer if appropriate. The practice worked with a community home for adults with learning disability to provide residents with care plans, health checks, and access to health promotion services, e.g. weight management and health screening.

Health education, screening and immunisation programmes were offered as appropriate.

The GPs worked with other health care professionals when caring for patients with drug and alcohol dependency. This included prescribing, promoting health, reducing risk, and managing health problems. Meetings took place with the community drug worker and clinical lead in drug and alcohol management.

Practice staff were able to refer patients to counselling services as appropriate. These support services visit the practice if the patient chooses this.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice had systems in place to identify patients with serious and enduring mental health problems. Each of these patients had a named GP and had been invited to an annual physical health check to detect cardiovascular, respiratory or diabetic conditions

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. This included regular meeting with local community mental health team and community psychiatry nurses (CPNs) to review shared patients.

Mental health medication reviews were conducted at the practice to ensure patients received appropriate doses of medication. Any patient taking specific medicines had regular blood tests to ensure safe prescribing.

The practice facilitated an NHS counselling, therapy and support service for people with anxiety, depression, stress and other mental health disorders.

There was an emphasis on diagnosis, treatment and support for people with dementia at the practice. This included identifying and flagging patients at increased clinical risk of dementia. Patients were also offered an assessment for dementia as part of the review of their relevant long term conditions if they choose to. Invitations to have an assessment for dementia were also offered to some patients attending for flu vaccination.

The practice held practice based education meetings with the Somerset Alzheimer's Society keyworkers and advisers, and GPs had attended further training on dementia.

There were representatives on the patient participation group (PPG) who had experienced mental health issues or were knowledgeable about the Mental Capacity Act and were willing to give feedback and support to staff at the practice.

Summary of findings

What people who use the service say

We spoke with eleven patients during our inspection and nine representatives from the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the

inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected seven comment cards, all of which contained positive comments. There were two negative comments about the new telephone appointment system.

Comment cards stated that patients appreciated the service provided, caring attitude of the staff and for the staff who took time to listen effectively. There were many comments praising GPs and the new nurses. Comments also highlighted a confidence in the advice and medical knowledge and not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback about the treatment and care from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, very satisfied and said they had no complaints and got good treatment. Patients told us that the GPs and nursing staff were excellent.

The majority of patients told us they were unhappy with the recent change appointment system. We were told a telephone triage service had recently been introduced, where patients call and are telephoned by the GP. The GP then decides whether the patient needs to be seen or can be managed over the telephone. Patients said if they wanted to speak with a doctor on the phone or were not worried about which doctor they saw it was a good system. However, patients with long term conditions said making routine appointments for ongoing monitoring was difficult and seeing the same doctor for continuity had been a problem. Patients told us they had completed a satisfaction survey which had been performed after the new appointment system had been introduced. The practice had listened to patients and had made some changes which were being communicated to patients. These included patients being able to book follow up appointments in advance.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. Some patients had done so about the appointment system and had been pleased with the response they had received. Other patients told us they had no concerns or complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the information provided and the practice website was good.

Areas for improvement

Action the service SHOULD take to improve

- All clinical staff receive training in the Mental Capacity Act (2005).
- Policies and procedures should be kept up to date and made available to all staff
- A health and safety audit should be repeated and action points taken forward.

Drs Harris, Hughes, Pearce, Trenholm and Tresidder

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Drs Harris, Hughes, Pearce, Trenholm and Tresidder

Springmead Surgery provides a service to approximately 6,500 patients in the Somerset town of Chard.

The practice is open between the hours of 08.00 and 6.30pm with appointments available from 08.30am. Evening appointments were available with a GP and nurse one day a week to help those patients who worked during normal office hours.

Springmead Surgery provides primary medical services to a diverse population age group and also provided a 24hour electrocardiogram (ECG-heart monitoring) to patients from other practices in the area. The practice was also a nominated yellow fever vaccination centre.

There was a team of five GP partners, four male and one female. GP partners hold managerial and financial responsibility for running the business. In addition there were two female GP trainees, three registered nurses, two health care assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, midwives and counsellors.

The practice had opted out of providing out-of-hours services to their own patients and refer them to the NHS 111 service.

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.

How we carried out this inspection

Before conducting our announced inspection of Springmead surgery, we reviewed a range of information we held about the service and asked other organisations to

share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 12 November 2014. We spoke with 11 patients and 15 members of staff at the practice during our inspection and collected seven patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, GPs, receptionists/clerical staff, and nursing staff. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with nine representatives from the patient participation group (PPG).

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, practice staff had been informed that incorrect information had been given to a patient regarding a contraceptive device. This had led to education for administration and nursing staff and a change in policy when using the device.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were discussed at the weekly partners Monday morning meeting agenda and more formally during a dedicated meeting was held three monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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. The GPs were currently discussing how they could expand the significant process to ensure that more nurses, administration and reception staff could be part of the process.

Staff explained the system they used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, practice staff had recognised a breakdown in communication regarding leg ulcer dressings. This had led to more structured meetings and communication with district nurse staff. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated verbally and by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details displayed on a flow chart were easily accessible in the main office area.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary advanced training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

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 and patients with mental health issues.

Good

Are services safe?

There was a chaperone policy, which was visible in consulting rooms. Selected staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which included inaccessible plug sockets.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There was a system in place to monitor the medicines and expiry dates kept in the GPs grab bag.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. For example, we saw an audit relating to the use of certain medicines in patients with diabetes. This showed that the majority of patients were on the correct medicines.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. The nurses had also received appropriate training to administer travel vaccinations and give travel advice. The practice had been nominated a yellow fever centre.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held very small stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were stored and managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Patients were pleased with the process of obtaining repeat prescriptions. The practice had established a service for people to pick up their dispensed prescriptions at a pharmacy of their choice and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that people collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The lead nurse had recognised the need for an infection control audit and had made changes including improvement to the cleaning equipment and introduction of more disinfecting hand gels. All staff received induction training about infection control specific to their role.

An infection control policy and supporting procedures were being updated and were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Good

Are services safe?

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

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

Records we looked at 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 criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us about the arrangement in place to cover each other's annual leave. For example, how blood tests were checked by other GPs in the absence of an individual GP.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There had been a large turnover of nursing staff in recent months and the practice manager was new in post. Existing staff said this process had been smooth and had added to the team well. The new nursing team were experienced in chronic disease management.

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 also had a health and safety policy which was in the process of being updated. Health and safety information was displayed for staff to see. There had been a fire safety fire risk assessment performed in February 2014. The practice were working through the actions to be followed up. Staff told us this included appointing fire wardens.

Staff told us any risks identified were usually addressed before formal meetings were held. For example, the changes following the infection control audit were introduced within 48 hours.

The practice manager informed us it had been recognised although they had contact details of organisations and companies to contact in the event of a disaster, they did not have a business continuity plan and were in the process of writing this.

A health and safety risk assessment had been carried out by the previous practice manager and was due for review. However, we saw that any action required had been addressed. For example, the manager was in the process of training and introducing fire wardens.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of drug overdose but informed us this medicine had been ordered because controlled drugs were stored at the practice. The practice informed us that they do not stock adrenaline 1 in 10,000 for use during cardiopulmonary resuscitation (CPR). We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this by maintaining CPR, using the defibrillator (a defibrillator is an

Good

Are services safe?

automated external device for providing emergency resuscitation to patients) and calling for emergency service are the priority. The practice manager told us they would discuss with the local cardiologist.

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. Patients were pleased with the care, treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The new nursing team had experience in managing long term conditions and planned to become more involved to support the GPs.

The practice had opted out of the national quality monitoring scheme and monitored their own outcomes. The findings we saw from last year were comparable other practices in the area. The practice also completed audits to ensure patients were receiving appropriate care and treatment. For example, an audit of the management of patients with dementia had reviewed the medicines prescribed and looked at ways of continuing to detect dementia. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed according to need.

National data and practice computer systems showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs used national standards for the referral of suspected cancers within two weeks. We saw systems used by administration staff to show how routine and urgent referrals were made.

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

Management, monitoring and improving outcomes for people

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 collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us five clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The GPs told us clinical audits were linked to medicines management information, safety alerts or as a result of information from the previously used quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit which looked at how GPs were monitoring patients on specific medicines with a heart condition. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service, documented the success of any changes ad set a date to repeat the audit.

The team were sharing clinical audits, learning from significant events, clinical supervision and staff meetings to review the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice and said there was an eagerness to learn. There was an expectation that all clinical staff should undertake audit as part of their revalidation or continued professional development.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that 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. Patients told us this worked well and that if it was a blood pressure check they were encouraged to use the machine in the waiting room at their leisure. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local schemes run by the clinical commissioning group (CCG). This included GPs working closely with local care and nursing homes and working with the multidisciplinary health and social care team to help prevent unnecessary hospital admissions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with annual basic life support and safeguarding training. However, staff were not clear about what other training had been decided as mandatory by the practice. Not all staff had received training in moving and handling and infection control. There was no overview or clear system in place to show what staff had received which training. This had been identified by the nurse lead and practice manager who were starting to introduce a more formal training programme.

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

All staff received annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and travel advice. Those with extended roles such as diabetes and asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had a process in place to follow up patients discharged from hospital. Staff said this system worked well and that the community matron or GP would visit vulnerable patients.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients. For example a monthly end of life/palliative care meeting was held and a

monthly multidisciplinary meeting was held to discuss vulnerable patients. The GPs explained that further specific discussions were held with other health care professionals where required.

The staff at the practice worked with other organisations in the community. One of the GPs worked with the clinical commissioning group and the practice manager was taking the lead on developing practice nurses management of long term conditions in the federation.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and showed us the back-up system to ensure the appointments had been arranged.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, although not all staff had received training in this subject but were aware of their duties in fulfilling it. The nursing staff understood the key principles and said they would refer to the GPs. The GPs shared examples of when they had implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse 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 chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-74. Practice data showed that 58% of patients in this age group took up the offer of the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. We saw that 72% of patients with learning disabilities had received a health check and review in the last year.

The practice's performance for cervical smear uptake was comparable to other practices in the CCG area. There was a policy to offer written reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The nursing team were responsible for following up patients who did not attend screening.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. These links were simple to locate.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent patient survey. This showed that 89.5% of respondents described the overall experience of their GP surgery as good or very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive about the recently introduced appointment system. The provider said they were aware of this and had now made changes which included being able to book routine appointments in advance. We also spoke with 11 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The common theme of negative feedback included the new appointment system which had prompted them to make their feelings known.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a wall which helped keep patient information private. A system was in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the office areas informing patents this service was available. Staff explained that a couple of workplaces in the town employ people from Eastern Europe who have become patients. Staff said having the translation service was reassuring but not used yet as patients had arrived with a good command of the English language.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice staff and said they had received help to access support services to help them manage their treatment and care when it had been needed. The patient comment cards we received were also consistent with this feedback. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that if families had suffered bereavement, their usual GP provided support. There were posters and leaflets offering advice on how to find a support service. We spoke with two patients who told us they had been treated very well following mental illness. We were told the practice staff recognised support was required and made sure this happened.

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 generally responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. However, feedback from patients and the patient participation group (PPG) informed us that a change in appointment system had been introduced with minimal consultation with patients. The practice staff had recognised this shortfall and had then responded by introducing changes and performing a patient survey.

The patient participation PPG told us they had been a group for approximately one year and had held five meetings so far and had a group of approximately 12 members. They told us the practice manager always attended but no GPs had attended to date. The practice manager said this had been fed back and discussions were being held about whether a GP should attend these meetings. The PPG told us they had been involved in forming the patient appointment survey and were in the process of collating results.

The PPG said the management at the practice had been responsive to suggestions made by the group, were approachable and swift to take action when it was identified. For example, automatic door openers had been introduced, waiting rooms had been tidied to provide less clutter and chairs had been replaced with easily cleanable seats. In addition, more hand gels had been introduced and a notice of the reception counter had been provided reminding patients to respect the privacy of the patient in front of them.

Tackling inequity and promoting equality

The practice provided equality and diversity training and staff confirmed that they had completed it.

The premises and services had been adapted to meet the needs of people with disabilities. For example the PPG had recognised automatic door openers would help patients in wheelchairs or those with mobility issues. There was a designated accessible toilet which had been fitted with grab rails.

The practice was situated on one level. The practice had open spaces in the waiting room which provided turning circles for patients with mobility scooters. Corridors and doors were wide making the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with prams and allowed for easy access to the treatment and consultation rooms. There were quiet areas for breast feeding mothers and baby changing facilities available.

Access to the service

Appointments were available from 08:30 am to 6pm on weekdays. Evening appointments were available with a GP and nurse one day a week to help those patients who worked during normal office hours. The appointment system had changed in recent months so that all patients phoned up the practice on the day they wanted an appointment. They would then be called back by a GP who would decide whether they could be treated over the telephone or would need to be seen. Patients said this worked very well if they needed to see a GP for an urgent issue on the day or if they were happy speaking with a GP on the telephone. However nine of the eleven patients we spoke with said this was an issue if a telephone call was difficult to receive because of privacy issues, convenience or because of hearing issues. Patients also said the new system had affected continuity of care for long term conditions unless they were able to find out which GP worked on which day. Patients with long term conditions said this system was difficult for making routine and follow up appointments for monitoring their conditions. We spoke with the practice manager who told us small changes had been made in the last ten days which included being able to make routine and follow up appointments. The practice manager said these changes were now being communicated to patients.

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

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns and were in the process of updating the policy. This was completed by the end of our inspection. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Three patients told us they had recently made complaints about the appointment system. They felt they had been listened to and were aware changes were planned.

We looked at the 21 complaints received in the last 12 months and found 10 related to the new telephone consultations and appointments. The practice manager had also written a complaint summary to look at trends. We saw that all complaints had been satisfactorily handled and dealt with in a timely way. We saw evidence of learning and changes in systems, policies and processes as a result of complaints. Any complaints about attitude of staff had been managed using employment processes. The complaints about the telephone appointment system had been addressed by the management team and had resulted in changes being made and a patient satisfaction survey being sent to all patients who had used the system to get further feedback.

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. This had been reviewed since the arrival of the new practice manager and team of practice nurses. We found details of the vision and practice values were part of the practice's strategy and business plan although there were no dates recorded for when this was to be achieved. We were told this was to be implemented in 2015.

Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. We were told there had been three or four social events in the past year to boost morale and team working. Staff said that even though many of the staff had changed the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. The lead nurse told us it had been recognised that many of the policies and procedures used by the nursing team were out of date and were being reviewed. We looked at the safeguarding adult and child policies and whistleblowing policies and saw these had been reviewed in the last year, whilst others such as the complaints policy had not been updated. This was addressed by the end of the inspection.

There was a clear leadership structure with 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 staff and they were all clear about their own roles and responsibilities. They all told us there had been a change in some roles but that they still felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had recently, with agreement of the local commission group, opted out of using the Quality and Outcomes Framework (QOF) to measure its performance. The old QOF data for this practice and the new data being collected showed it was performing in line with national standards.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at five examples of clinical audit which followed good practice guidelines for audit. For example, the practice looked at the management of patients with diabetes and hospital admission. The practice measured the care and services provided implemented changes in practice where necessary and re audited to make sure care and treatment was still appropriate.

The practice manager has started to introduce a process for identifying, recording and managing risks. The practice manager showed us the last risk assessment which had been performed in 2006. This had led to a fire risk assessment which had been performed in September 2014 and included a list of actions which had started to be addressed. For example, administration staff told us they were due to attend fire warden training.

The practice held weekly partners meetings where complaints, significant events and incidents were discussed along with day to day events. The records for these events showed the action and learning that took place. We were told that there was a plan to introduce a more formal three monthly meeting where all staff could attend and hear about any significant events.

Leadership, openness and transparency

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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment procedures and induction process which were in place to support staff. Staff knew where they could find these.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a patient survey in March 2013. The survey found survey found that most patients felt that both our doctors and nurses gave them enough time, asked about symptoms, listened well, and explained tests and treatments. The majority of patients also said the GPs involved them in their care, treated them with care and concern and took their problems seriously. The survey also reported that 95% of the patients who responded felt GPs had helped them to manage their condition. The survey findings had prompted a change in the way patients made appointment. This had

Are services well-led?

Good

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

not proved to be popular with patients. The practice had recognised they had not involved patients as much as they could and promoted the patient participation group (PPG). The practice have since conducted a focused survey on the appointment system and made changes which included being able to pre book routine and follow up appointments.

The practice had a PPG which had 12 members. The PPG included representatives from various population groups; including patients with long term conditions, working age patients and patients with mental health issues. The PPG had influenced the recent patient survey. The PPG said the practice manager had been approachable and open to suggestions.

The practice had gathered feedback from staff through face to face discussions, appraisals and through any staff meetings. 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 took place which included a personal development plan. Nursing appraisals had been recommenced since the arrival of the new lead nurse. Staff told us that the practice was very supportive of training.

The practice was committed to NHS workforce planning. They had employed an apprentice on the administration team who was now fully employed and working towards a medical secretary qualification. The practice was also a GP training practice and had two GP trainees being supported by the GPs at the practice. We spoke with one GP trainee who had been at the practice for four months. They told us they felt well supported, had received an induction and had weekly training sessions with the partners. The lead nurse was in the process of doing a mentorship course to enable to the practice to support student nurses.

The practice had completed reviews of significant events and other incidents. The GPs were in the process of introducing more formal ways of sharing action and learning from these events with the wider staff group to ensure the practice improved outcomes for patients.