Dr B. B. Roy & Partner

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr B. B. Roy and Partner on 29 May 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 all of the population groups we looked at.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice pro-actively monitored patients to identify adult and child safeguarding issues.
- The practice identified learning and took action in response to significant events but this was not always recorded.
- Risks to patients were assessed and well managed. Staff recruitment procedures were robust.
- Performance was being monitored, areas for improvement were being identified and action was taken to achieve progress.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received appropriate training for their roles and further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice notes of patients receiving a multidisciplinary package of care were not always updated with the most recent care and treatment decisions, although they were recorded on the relevant register.
- Information about services and how to complain was available and easy to understand.
- Patients generally found the appointment system met their needs but had experienced difficulties getting an appointment of their choice with the GP and nurses.
- The practice provided continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff.
- The practice had not undertaken a patient survey to seek the views of patients.

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

Importantly the provider should;

- Undertake a patient survey to seek a broader view of the services provided.
- Update patient notes when changes to care and treatment have been discussed and agreed at multidisciplinary meetings.
- Implement a system to regularly review medicine alerts.

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 report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed but where learning had been identified the action taken was not always recorded. All staff had been trained in safeguarding procedures for vulnerable adults and children. Robust systems were in place to actively identify safeguarding issues. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had safe, robust infection control procedures. Emergency and other medicines were stored safely and monitored for expiry dates to ensure they were safe for patients.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average compared with others in the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Clinical and non-clinical audits took place to identify areas where the practice could improve for the benefit of their patients. 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 all staff. Staff worked with multidisciplinary teams other to improve patient outcomes. Health promotion advice was readily available.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. Patients were involved in the decisions about their care and treatment. Carers were supported and offered advice and guidance.

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

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients were generally satisfied with the appointment system but on occasions found it difficult to get an appointment with the GP and nurses. Telephone consultations and home visits were available if required. Patients could access GPs at the weekends by appointment. Patients with urgent health needs were prioritised. Information about how to complain was available and easy to understand. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings where governance issues were discussed. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice did not have a patient participation group (PPG). The practice had not conducted a recent patient survey. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Same day appointments, telephone consultations and home visits were available for the elderly or house-bound. Longer appointments were available if required. Patients over 75 received a structured health assessment and had a named GP. Medicines could be delivered directly to their home address. Multidisciplinary meetings took place with other healthcare professionals to identify the most appropriate care and treatment to avoid unplanned hospital admissions. The practice worked with community health services so that care could be provided in patient's homes if required. Frail patients had care plans in place and falls were being monitored and referrals made when necessary. The practice offered proactive, personalised care to meet the needs of older patients with dementia or requiring end of life care. Flu vaccinations were available and patients were contacted if they had not attended the practice. Joint injections were available for patients.

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 had received appropriate training. Patients at risk of hospital admission were identified as a priority and their condition monitored. Chronic disease clinics were in place to monitor patients' conditions. Longer appointments and home visits were available when needed. The practice was pro-active in undertaking regular health reviews. Patients with complex health needs received continuity of care and the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients in need of same day appointments due to their long-term condition or with urgent health care needs were prioritised. Patients' mental health was monitored in relation to anxiety and stress caused by their condition. Monthly palliative care meetings took place with other healthcare professionals. A phlebotomy service was available at the practice for patients on anti-coagulation medicines.

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 identified as 'at risk.' All clinical staff had received an

appropriate level of safeguarding training. The attendance of children who had a high number of A&E attendances was monitored. Immunisation rates were high for all standard childhood immunisations as compared with other practices in the local area. Patients told us that children and young people were treated in an age-appropriate way. Appointments were available outside of school hours and the premises were suitable for children and babies. Children under the age of five were seen on the same day. Staff were aware of consent legislation in relation to children and young persons. Contraception and sexual health services were available for patients to access. Cytology testing was available and patients were pro-actively encouraged to attend appointments for screening. Six week baby checks and post-natal examinations took place to ensure young children's health was being monitored effectively.

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. Online services were available to book appointments and order repeat prescriptions. Extended opening hours were available through the week and appointments available on Saturday and Sunday mornings. The practice provided health screening for working age people to check on their health. Return to work advice and fitness guidance was available to patients returning to work after illness.

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. Staff were pro-active in identifying patients at risk of abuse. Staff had received additional training to support patients with learning disabilities. Longer appointments were available for vulnerable patients if required. Patients could be referred to advocacy services if advice and support was required. The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. Patients with a learning disability received an annual health check or sooner if required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were signposted to various support groups and voluntary organisations. Staff were aware of their responsibilities regarding information sharing, documentation

of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice had access to sign language interpreters for patients with hearing or speech problems.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice identified patients with dementia and provided consultations, advice, annual health reviews and they were monitored through the use of a register. The practice took a multidisciplinary approach to patients and involved them in identifying the most appropriate care and treatment that met their needs. The practice advised patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice worked with a dementia crisis support centre. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. Dementia care support was offered and referrals made to a dementia memory service. The use of medicines used by patients suffering with poor mental health was monitored regularly.

Summary of findings

What people who use the service say

Prior to our inspection, comment cards were left with the practice for patients to complete to give their views of the practice, including whether staff were kind and caring and whether their needs were being met.

We reviewed 49 cards that patients had completed. The majority of patients made positive comments about the practice and it was evident that they were satisfied with the services provided. They commented that the GPs, nurses and reception staff were all kind and caring and they were treated with dignity and respect. They said that GPs and nurses had time to spend with them discussing their care and treatment needs and they explained things clearly. Several patients commented that there had been considerable improvements at the practice in the last 12 months. Some patients said that they found it difficult to obtain appointments that suited them with the GPs and the nurses. Other patients were satisfied with the appointment system.

We spoke with two patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. They told us they were given time during consultations and their diagnosis, care and treatment was clearly explained to them. They said they were treated with dignity and respect and felt involved in the decisions about their care and treatment.

The practice had started the NHS Friends and Family test and patients had submitted completed satisfaction cards for the first three months of the year. The majority of patients that had completed this test expressed that they were either extremely likely or likely to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Undertake a patient survey to seek a broader view of the services provided.
- Update patient notes when changes to care and treatment have been discussed and agreed at multidisciplinary meetings.
- Implement a system to regularly review medicine alerts.

Dr B. B. Roy & Partner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector accompanied by a GP specialist advisor.

Background to Dr B. B. Roy & Partner

Dr B. B. Roy and Partner is located in Stanford Le Hope, Essex. The practice is situated in a residential house that has been adapted to meet the needs of patients. The practice is one of 34 GP practices in the Thurrock Clinical Commissioning Group (CCG) area. The practice has a general medical services (GMS) contract with the NHS. There are approximately 2700 patients registered at the practice.

There are up to three GPs working at the practice (one male and one female) and one of them is a partner. A third GP is available to cover GP absences. On most days only one GP is working at the surgery except on Wednesday afternoons when there are two. The GPs are supported by two nurses who work a total of one and a half days each week. There is a practice manager and six receptionists who share the role throughout the week.

The surgery is open Monday to Friday between 8am and 6pm and GP surgeries run in the mornings and afternoons at various times. The practice is closed Thursday afternoons. There are three late nights until 7pm on Mondays, Tuesdays and Fridays. The practice works closely with three other practices in the local area to provide weekend appointments for working patients on a shared basis on Saturday and Sunday mornings. Patients can pre-book appointments and have to travel to one of the other practices for consultations.

The practice has opted out of providing 'out of hours' services which is now provided by the contractor commissioned by NHS England. However on Thursday afternoons between 1pm and 6.30pm when the practice is closed, patients can contact the South Essex Emergency Doctor Service in an emergency. Patients can also contact the non-emergency 111 service to obtain medical advice if necessary.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We then carried out an announced visit on 29 May 2015. During our visit we spoke with a range of staff including two GPs, the practice manager and two members of the reception staff. We also spoke with two patients who used the service. We observed how people were spoken with at reception and reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice and 49 of them had been completed. We reviewed the comments made by patients on those cards.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. There was a system in place for the reporting and management of safety incidents, significant events, national patient safety alerts, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and significant events and found that they had been recorded and analysed with areas for improvement identified. There was a system in place to make staff aware of any incidents that occurred and the learning from them. This took place during team meetings and informally. Minutes of meetings reflected that learning had discussed. This showed that 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

The practice had a system in place for reporting, recording and monitoring significant events and safety incidents. This involved the use of a structured template that was available for staff to use to record such events. Staff spoken with were aware of the procedures to follow and who to notify if a significant event occurred. The significant events were forwarded to the practice manager for discussion at the next practice meeting after being analysed, investigated and learning had been identified.

We reviewed the records of eight significant events that had occurred during the last 12 months. We found that they had been analysed effectively and learning identified and where appropriate, action had been taken to reduce the risk of a reoccurrence in the future. However the practice was not recording the names of the staff members responsible for introducing changes arising from significant events and an audit trail that reflected the dates when action had been taken. The practice agreed to record this in greater detail in the future.

One significant event identified an error in prescribing from secondary care after a patient had been discharged from hospital. One of the receptionists dealing with a hospital discharge letter had noticed an unusual dose of medicine that had been issued by the hospital. They made correct use of their reporting system and notified the practice manager. Subsequent analysis revealed an error by the hospital and the patient was not put at any risk. This was discussed and feedback supplied to the hospital.

The practice held regular team meetings and minutes were recorded. They also held informal discussions during the week to keep up to date with learning identified form safety issues and significant events. Minutes of meetings were made available to each staff member so they could keep up to date on any matter if they had been absent from work for any reason. Each staff member had their own personal folder where they stored minutes of meetings.

The practice had a duty of candour policy that outlined the action to take in the event that mistakes had been made. This included being open and honest with patients, providing them with an explanation and an apology and by explaining any action taken to prevent a repeat of the same incident. Patients were given the opportunity to attend the practice in person and discuss the issue with the practice manager or GP.

National patient safety and medicines alerts were disseminated by the practice manager to the GPs for their clinical input. They were provided with a written copy of the alert and required to indicate on the copy the action to take if they affected any of their patients. We found that the practice undertook searches on their computerised patient record system to identify patients that were affected by the alerts to ensure they were receiving the correct medicine. We conducted a search on their system and found six patients where medicines had not been changed after the date of the initial search. The practice should have a system in place to re-run specific searches to ensure that the medicine alert is kept under regular review to ensure that patients had not been missed or prescribed the medicines in error by visiting clinicians.

GPs we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice manager told us that one example of an alert related to the use of emergency medicines for patients who suffered severe allergic reactions. Those patients affected by the alert were identified and contacted. They attended the practice and were supplied

with alternative treatment. They also told us alerts were discussed at staff meetings 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. The practice had identified a lead for safeguarding and this was one of the GPs. All GPs at the practice had received safeguarding training to enable them to fulfil these roles.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff spoken with 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 for the safeguarding team were easily accessible. We were told that there was a positive relationship with the Thurrock local authority safeguarding team and they were consulted regularly.

One staff member told us that they had introduced a 'one click' facility on the practice computer system. This enabled staff to click on an icon on their computer screen and then details of safeguarding procedures and contacts would display immediately so that they could easily follow the correct processes and access the reporting forms.

The records of staff meetings were very detailed and reflected that safeguarding and vulnerable adult's issues were being shared with staff.

We found that the practice was particularly pro-active in identifying safeguarding issues amongst their patient population. Systems were in place to monitor both child and adult attendances at A&E, hospital discharge letters, those patients transferring from other practices and those that did not attend for a scheduled appointment. If a risk was indicated staff would alert the practice manager and if necessary, the local authority would be contacted. One such example related to a patient who had attended A&E a number of times for the same type of injury. This was sent as a safeguarding alert to the local authority. It was apparent from staff we spoke with that safeguarding was a priority at the practice.

Vulnerable adults and child risk registers were updated monthly and all staff were made aware of those on the registers to ensure that when they attended the practice all were aware of the concerns affecting them. There was a system to highlight vulnerable patients on the practice's computerised records. This included information to make staff aware of any relevant issues when patients attended appointments. Those children on the practice 'at risk' register who required appointments were always seen on the same day whenever possible.

Staff we spoke with told us that they were encouraged to raise safeguarding or safety issues. They said there was a 'no blame' culture at the practice. All staff had received whistle blowing training and a policy was in place for them to refer to if required. They were aware of who to contact outside of the practice if required.

The practice had a chaperone policy and signs were displayed in the reception area to inform patients that they were available for them if required. (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 used reception staff as chaperones with the occasional use of one of the nurses. The receptionists had not received formal training but understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Reception staff undertaking chaperone duties had not received Disclosure and Barring Service (DBS) checks. (DBS 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). Staff who had not received chaperone training were not left alone with patients. A record was made in the patient's notes when a chaperone had been used.

We found that there was no risk assessment in place that covered the use of reception staff as chaperones that had not received formal training or a DBS check. The practice was aware that training for reception staff was required and had already planned this for August 2015. The practice told us that they would undertake DBS checks on staff carrying out chaperone duties or undertake a risk assessment as to why one was not necessary.

Medicines management

Good

Are services safe?

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a system in place to ensure that medicines were kept at the required temperatures and stock was rotated regularly. The fridge had an audible alarm if the temperature went above the maximum allowed to keep medicines safe and fridge temperatures were being recorded daily. A second fridge was available for use if there were any repair issues or faults.

We were told that one of the fridges had failed to operate and required replacing. This was done in a timely manner, medicines transferred to the second fridge and medicines remained effective. The new fridge contained a computer card that recorded the temperatures and this was being checked annually.

The practice had a system for dealing with the delivery of medicines that were required to be stored in a fridge. Their cold chain policy explained the procedure for staff to follow. Medicines were placed in the fridge as soon as they arrived to prevent them deteriorating. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Patient's records were marked up when a medicines review was due. This included a system where some patients were required to attend for a personal review and/or blood test to discuss their medicines with a GP, to ensure they were effective and still necessary. Prescriptions were also clearly marked so that the patients were aware of their review date and local pharmacies were advised when reviews were due. Staff were unable to print off prescriptions if the review date had passed.

Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Serial numbers were recorded when prescription pads were distributed to the GPs.

The practice had established a service for patients to pick up their dispensed prescriptions at local pharmacies and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

We saw records of practice meetings and audits that noted the actions taken in response to a review of prescribing data. One such review involved the prescribing of medicines to reduce inflammation. The practice was aware that the data reflected that their prescribing rates were high in comparison with the local average. A review identified the number of patients taking these medicines and this enabled the practice to considerably reduce the number of patients receiving this medicine. This impacted on both the safety of the patient and a reduction in costs.

A further initiative included providing health information to patients in relation to avoiding routine antibiotic prescribing for viral infections and reviewing the way they were being prescribed at the practice. The result of these reviews had reduced the prescribing budget and we were told by staff that the latest data put the practice as second best for value for money in the local area. This also had a positive effect on patients in relation to the treatment they received and their safe use of medicines.

Cleanliness and infection control

A lead had been identified for infection control at the practice and this was one of the GPs supported by one of the nurses. They had received appropriate training to carry out their roles. All other staff had received training about infection control specific to their role and received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We observed the premises to be visibly 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.

Good

Are services safe?

The practice employed a contract cleaner who was responsible for the cleanliness of the premises. A document was available that identified the risks associated with the use of cleaning materials and this complied with the Control of Substances Hazardous to Health regulations (COSHH). A cleaning schedule identified the areas to clean, the materials to use and the frequency. Every two years the practice undertook a deep clean of the premises. The quality of the cleaning was being monitored by the practice manager on a regular basis and recorded.

Infection control audits were carried out annually and records we viewed reflected that systems and processes were robust. The most recent infection control audit was carried out by an external contractor. Where areas for improvement had been identified, these had been actioned or there was a timeframe in place for completion. One such example included reducing the risk of legionella (a bacterium which can contaminate water systems in buildings) by implementing a system to run hot and cold taps weekly for three minutes to reduce the risk and this was being recorded. Another improvement area identified that the waiting room chairs should be replaced with a type that could be more easily cleaned. This had been actioned. Minutes of practice meetings showed that the findings of the audits were discussed.

All staff at the practice had received infection control training. There were adequate supplies of hand gel and hand towel dispensers were available in treatment rooms. . Alcohol hand gel was also available in the reception area for the use of patients and staff. Notices about hand hygiene techniques were displayed in staff and patient toilets. Staff were required to demonstrate to a supervisor that they understood hand washing guidance and this was recorded in their personal files. Staff spoken with confirmed that they had completed this training.

Equipment

Staff we spoke with told us they had sufficient quantities of equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We viewed the servicing and maintenance records and confirmed that this had been taking place over a number of years. This included portable appliance testing (PAT) for electrical devices and the calibration of diagnostic equipment such as blood pressure monitors and weighing scales.

One recent improvement was the purchase of a 24 hour blood pressure monitoring device. This was a result of guidance from the National Institute for Health and Care Excellence to improve the reliability of the diagnosis of high blood pressure.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice undertook Disclosure and Barring Service (DBS) checks on clinical staff only. 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.

However reception staff routinely carried out chaperone duties and these staff members had not received DBS checks. We discussed this with the practice on the day of the inspection and they agreed to ensure that those staff carrying out chaperone duties receive a DBS check or a risk assessment if they are not going to be left alone with patients. They also agreed that when new staff are employed at the practice that they will outline their rationale if a decision is made that a DBS check is not required for a particular role. The practice have since contacted us and assured us that this process is now in place.

We looked at two files of staff recruited in the last two years. One of them was a clinical member of staff and one non-clinical. Records for the clinical member of staff reflected that appropriate recruitment checks had been undertaken prior to employment. This included proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The records for the non-clinical member of staff also contained the appropriate documentation except for a DBS check or a risk assessment that explained why this was not necessary. For both members of staff we were told that they were known to the practice and had worked locally for a number of years so verbal references had been taken rather than written ones. Whilst this was acceptable this had not been recorded in the staff files. The practice agreed to record details of verbal references for any new staff employed at the practice.

Good

Are services safe?

New members of staff had to undergo an induction process so that they could familiarise themselves with the way the practice worked. This included how the appointment system operated, the location of the emergency medicines and equipment and health and safety procedures such as the action to take in the event of a fire.

The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice employed few staff members only and during periods of annual leave, training or other absence staff were able to cover for each other's absence. Locum GPs or nurses had not been used for a number of years as GPs were also able to cover for each other in the event of an absence. This was confirmed by all members of staff we spoke with on the day. We found that overall there were enough members of staff on duty at all times. A system was in place to check on the skills, qualifications and experience of locums should the need arise.

Monitoring safety and responding to risk

The practice had a health and safety policy and risk assessment to ensure the design, use and maintenance of the premises kept staff and patients safe. The building and environment were checked monthly and where defects or issues had been identified these were rectified. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice was limited to the amount of structural changes that could be made due to cost and the design of the building, but had implemented safety measures to protect patients and staff wherever they could. One such risk was a trip hazard in one of the reception rooms. The practice was unable to undertake structural improvements to remove the risk so the area was clearly marked with orange and black hazard tape to make it visible and patients were warned of the hazard when they attended the practice.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. A system was in place to monitor patients who did not attend for their appointment and an audit took place monthly. If this occurred their individual health condition was looked at to identify if there were any concerns in relation to their non-attendance that might have affected their health or highlight a safeguarding issue. This included patients with long-term conditions, children, the elderly, those suffering with poor mental health and patients at risk of an unplanned hospital admission.

Arrangements to deal with emergencies and major incidents

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (heart attack), anaphylaxis (sudden allergic reaction) and hypoglycaemia (low blood sugar). 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, fit for use and records of these checks had been maintained.

The practice had arrangements in place to manage emergencies. Records showed that sufficient numbers of staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly to ensure that it was in working order and the battery charged. We checked that the pads for the automated external defibrillator and found they were within their expiry date and that the battery was charged and ready for use.

The GPs used an emergency bag when visiting patients away from the practice. They were kept in a locked cabinet at the surgery when not being used. We looked at the medicines in the bag and found that it contained an extensive list of recommended medicines that were in date. There was a system of monitoring expiry dates and records were being kept of these checks on a regular basis.

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 refer to.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training procedures in the event of a fire and alarm testing had been reviewed in July 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

One of the GPs monitored Clinical Commissioning Group (CCG) guidelines and attended regular meetings organised by the CCG. They also followed relevant NICE guidance online and contributed to webinar sessions to keep up to date on current practices. This GP then prepared summaries of any changes in guidance and distributed them to colleagues at the practice. On speaking with this GP they were able to demonstrate that they had kept up with the latest guidance and these included chronic kidney disease and cardiac management.

GPs and nursing staff described how they carried out comprehensive assessments which covered all health needs in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

The practice identified and monitored those patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure all their needs were continuing to be met. Data available to us reflected that unplanned admissions were at similar levels nationally to other GP practices.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that 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.

Clinical staff had received training in specialist areas such as diabetes, heart disease and asthma and the patients with these conditions could attend clinics to have their health assessed and appropriate care and treatment put in place. Clinical staff we spoke with received support from colleagues when required, including discussions about new best practice guidelines.

We found that where discussions took place with other healthcare professionals as part of a multidisciplinary approach. The minutes of meetings held with other healthcare professionals were documented to reflect that care and treatment plans had been agreed but this was not always updated in patient records. The practice agreed to action this in the future.

Management, monitoring and improving outcomes for people

The practice monitored their effectiveness through the Quality and Outcomes Framework. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice was aware of their QOF performance and met regularly as a team to discuss it. 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. Improvements had been made since the year end to March 2014 and we were told that data up to the year end March 2015 indicated that they had achieved 95% of their clinical targets.

The practice agreed to sign up to additional services to support patients at risk of an unplanned hospital admission and the regular review of patients with a learning disability. The practice was meeting the targets set for them in relation to these services.

In relation to avoiding unplanned admissions the practice had identified those patients at risk of their condition deteriorating rapidly and regularly monitored them. They were provided with a care plan that reduced the risk of an admission. Patients who had received A&E treatment were reviewed to see if there were any steps that could have been taken to avoid a repeat admission. This included calling them at home after discharge to establish their care needs and providing a home visit by one of the GPs or nurses.

Good

Are services effective?

(for example, treatment is effective)

The practice had undertaken a number of clinical and non-clinical audits. These included heart failure, medication reviews and consent. One such audit looked at joint injections, whether any complications had occurred and whether consent had been taken appropriately. The audit reflected that there had been no complications and written consent had been obtained.

The practice was aware of the performance data for the practice to the year end March 2014 that reflected that in some areas their performance was below national QOF averages and we saw action plans setting out how these were being addressed. This included diabetes monitoring where the practice had undertaken a comprehensive review of their systems. The practice had identified where they could improve and had addressed the underperformance. We were told by the practice that the data for the year end March 2015 reflected that they had achieved 95% of their targets which was an improvement on the previous year.

One particular area of note was in relation to dementia diagnosis. One of the GPs at the practice had made significant progress to identify the prevalence of those suffering with dementia so that they could be monitored more effectively. The latest data reflected that improvements had been made.

The practice had a register of patients with significant mental health needs and of those with learning disabilities. They received annual health reviews or sooner if required and this included monitoring their medicines and whether they were having a positive effect. We found that patients were being monitored effectively including whether they were affected by changes in medicines requested by specialists in secondary care.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. We saw an audit regarding the use of non-steroidal anti-inflammatory medicines. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines.

The practice prescribing rates were similar to expected as compared with other practices locally and nationally. Where the data was lower than expected the practice was aware of it and had taken appropriate steps to improve their prescribing. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computerised patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Specific examples to demonstrate this included:

- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- The percentage of patients with atrial fibrillation, measured within the last 12 months, who were treated with anti-coagulation drug therapy or an anti-platelet therapy was similar to the national average.

The practice had introduced a system that achieved value for money and made blood/sugar monitoring easier for patients with diabetes. This involved them being supplied with a free blood/sugar tester and a more economical way of funding test strips through the prescription system.

One patient spoken with on the day of our inspection told us that their long-term health condition had been effectively monitored and treatment changed to improve their quality of life and the management of their illness. This involved a change of medicine that had brought them considerable improvements and increased their independence.

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 attendance at courses such as annual basic life support, safeguarding and infection control. We found that staff undertaking the roles of chaperone had not received any formal training but this

Good

Are services effective?

(for example, treatment is effective)

had already been recognised by the practice and had been booked for August 2015. However staff spoken with were aware of the role of the chaperone and where to stand during an examination.

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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We noted a good skill mix among the GPs, nurses and non-clinical staff. Training was being monitored and this included the date of the last training and when refresher courses were due. Nurses working at the practice had received a range of training including infection control, cytology, diabetes management, immunisations and learning disabilities.

All staff received annual appraisals that included a two way discussion about their performance throughout the year, training and learning needs and any career development that was identified or requested. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. Staff spoken with told us that they were supported to carry out their roles and said that it was a nice place to work. They confirmed that the GPs and managers were always available for advice and guidance and supportive of training and their development. All staff spoken with commented that the training they had received met the needs of the patient population.

Staff at the practice were provided with a job description outlining their roles and responsibilities and were able to provide evidence that they were trained appropriately to fulfil these duties. These included roles treating patients with long-term conditions such as asthma, chronic obstructive pulmonary disorder and diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support those 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.

The information received was passed to one of the GPs for clinical input to ensure a follow-up or a change of medicines was made of if required. The patient's record was then updated by support staff, after noting any comments made by the GPs. Discharge summaries, out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. The practice used a stamp so there was a clear audit trail that the GPs had seen the documents and made a record as to the action required. We found that there were no outstanding reports at all on the day of our inspection. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were average compared with national and local data. 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). We were told that patients attending A&E were reviewed to establish whether care and treatment could be put in place to reduce the risk of further admissions. In addition, those patients deemed at risk were recorded on a register and their care and treatment reviewed more regularly to reduce the risk of an unplanned admission.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs, including those with palliative 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. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We found that patients were receiving care and treatment that met their needs and care plans were being updated but we found some examples of where the patient's practice record was not being updated. The practice agreed to amend their system to ensure patient records were updated.

One patient spoken with told us of their experience having been referred to a specialist after a consultation with one of the GPs. They found that when discharged from the

Good

Are services effective?

(for example, treatment is effective)

specialist their next visit to the GP reflected that they were up to date on the specialist treatment they had received and were aware of all the treatment that had been recommended.

The practice told us that they had the lowest use of the 111 system compared with other practices in their local area.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an computerised patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system that enabled scanned paper communications, such as those from hospital, to be saved for future reference.

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

A member of support staff summarised patient records onto the computerised patient record system. Staff were aware of the need to maintain confidentiality when sharing information with other healthcare professionals.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

A consent policy was available for staff to refer to and this identified the different types of consent that could be taken and that it could be withdrawn by a patient at any time.

All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). Reception staff spoken with were aware of Gillick competence and told us that children presenting themselves at reception for an appointment, without a parent/guardian, would be referred to one of the clinical staff if they did not wish their parent/guardian to be notified.

We found that verbal and written consent were recorded appropriately. Where nursing staff administered child immunisations they ensured that the adult attending with any child was legally entitled to consent. If not, the procedure was stopped and the legal guardian contacted.

Nursing staff had received training in relation to patients with a learning disability and supported patients to make decisions with explanations given in a way they understood. This involved consulting with relatives and carers, seeking written consent from patients to discuss their care needs with relatives/carers and the completion of care plans to manage their care and treatment needs. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it.

Health promotion and prevention

The practice was aware of the strategic objectives set by the Clinical Commissioning Group and directed their services towards them. This information was used to help focus health promotion activity.

The practice offered smoking cessation advice to their patients. The practice was pro-active in identifying patients who smoked and offered them support and guidance. The practice also lifestyle guidance and support to patients that were obese. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice's performance for the cervical screening programme to the year end March 2014 was 71%, which was below the national average of 82%. The practice was aware of this and had implemented an action plan for improvement. The practice had looked at ways of improving their performance including following up those who did not attend and the use of text message and opportunistic reminders when patients attended the surgery on other health matters. We were told that an improvement had been made.

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 above average for the majority of immunisations where comparative data was available. For some immunisations the practice had achieved a 100% success rate.

The practice monitored non-attendance for childhood immunisations. They told us of an example where a

Good

Are services effective?

(for example, treatment is effective)

vulnerable family had failed to attend to receive immunisations for their children. They had been contacted and invited into the practice to establish the reasons and to encourage them to receive them.

The practice performance for flu vaccinations for the elderly or those vulnerable through other reason was in line with national averages. This service was advertised to patients in the reception area and on their website.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting 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. The practice made use of a radio playing in the background throughout the waiting room and reception areas to further reduce the risk of consultations being overheard.

Patients could phone the practice for test results from 12 noon each day. Staff were aware of the need for confidentiality and took appropriate steps to confirm the identity of callers before passing on the results. Staff speaking with patients at reception were careful not to disclose private information about patients attending for appointments. If a confidential matter needed to be discussed patients were taken to a private room.

We spoke with two patients on the day of our inspection who told us that they were treated with dignity and respect, that staff were kind and caring and their privacy was respected. They found the GPs and nursing staff compassionate and said they spent time listening to their concerns.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in July 2015. The results reflected that;

- 83% of patients found that the receptionists were helpful compared with 88% locally and 87% nationally.
- 92% said the GP was good at listening to them compared with 85% locally and 89% nationally.
- 89% said the nurse was good at listening to them compared with 92% locally and 91% nationally.
- 91% said the GP gave them enough time compared with 82% locally and 87% nationally.
- 87% said the nurse gave them enough time compared with 91% locally and 92% nationally.
- 97% said they had confidence and trust in the last GP they saw compared with 92% locally and 95% nationally.
- 92% said they had confidence and trust in the last nurse they saw compared with 96% locally and 97% nationally.

Patients completed 49 CQC comment cards to tell us what they thought about the practice. The majority were very 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. Some patients commented that it was sometimes difficult to get an appointment with the GP and the nurses at a time that suited them.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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.

Two patients we spoke with on the day of our inspection told us that the GPs and nurses at the practice involved them in the planning of their care and treatment and provided clear explanations to them.

Data from the national patient survey published in July 2015 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 91% said the last GP they saw was good at explaining tests and treatments compared with 80% locally and 86% nationally.
- 77% said the last GP they saw was good at involving them in decisions about their care compared with 75% locally and 81% nationally.
- 85% said the last nurse they saw was good at explaining tests and treatments compared with 89% locally and 90% nationally.

Good

Are services caring?

- 75% said the last nurse they saw was good at involving them in decisions about their care compared with 84% locally and 85% nationally.

The practice involved carers and relatives where consent had been received, when making decisions about care and treatment. This included older people and those with long-term conditions.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were positive about the emotional support provided by the practice and rated it well in this area.

Data from the national patient survey published in July 2015 reflected that;

- 87% said the last GP they spoke to was good at treating them with care and concern compared with 79% locally and 85% nationally.
- 88% said the last nurse they spoke to was good at treating them with care and concern compared with 89% locally and 90% nationally.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. The practice computerised patient record system alerted staff if a patient was also a carer.

Staff told us that if families had suffered bereavement, they were notified and could offer relatives care and support, including a consultation with the GP. They were referred to support services if required.

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 patient'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. The practice was aware that they had a high proportion of elderly patients and they tailored their services to meet their needs and those of other patient groups.

One of the GPs monitored Clinical Commissioning Group (CCG) guidelines and attended regular meetings, to keep up to date with local needs and service improvements that needed to be prioritised. This GP then cascaded these proposed improvements to colleagues at the practice.

Patients over the age of 75 were allocated a named GP and could see a GP of their choice when they were available.

The practice had an unplanned admissions register where they monitored those patients identified as at risk of their health deteriorating rapidly. Their health condition was regularly reviewed and they were provided with individualised care and treatment to reduce the risk of having to attend the hospital for emergency treatment. This included a care plan and the involvement of community services. Regular multidisciplinary meetings took place where their care and health condition were monitored and discussed.

Longer appointments were available for patients with multiple or complex needs and those with learning disabilities or suffering from poor mental health. For patients who were house-bound, home visits were available.

Registers were in use for those patients with long-term health conditions and regular reviews of their health condition took place. The practice ran a number of clinics to monitor the health of patients with long-term conditions such as asthma, chronic obstructive pulmonary disease and diabetes. Appointments could be booked with the nurses at the practice who monitored their condition and provided lifestyle advice and guidance to support them.

A system was in place to identify and provide services to mothers and babies. Post natal clinics were held at the practice. Childhood immunisations were available via appointment and the nurses and GP carried out six/eight week baby checks. Family planning advice was available including the fitting of contraceptive devices.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to their premises so that disabled patients and those with limited mobility could access the service easily. The practice had installed a ramp and supporting rail so that patients with limited mobility or using wheelchairs could enter the premises safely. There was no toilet for the disabled due to the limitations of the building but the practice had considered it.

The reception area was spacious and available for wheelchair users. A raised chair was available for patients that found it difficult getting out of chairs of a standard height due to their restricted mobility.

The practice had a number of vulnerable patients at the practice including those with learning disabilities and dementia. Their services were planned accordingly to meet their needs and staff had received training to be able to support them when necessary.

We found that the practice registered as patients those who had 'no fixed abode'. There was a system for flagging vulnerability in individual patient records.

Access to the service

The surgery was open Monday to Friday between 8am and 6pm and GP surgeries ran in the mornings and afternoons at various times. The practice closed on Thursday afternoons when the out of hour's service was available for patients. There were three late nights until 7pm on Mondays, Tuesdays and Fridays. The practice was closed at weekends but a local protocol between practices meant that patients could access weekend appointments at one of the other practices in the immediate vicinity on Saturday and Sunday mornings.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

Appointments could be booked in person, by phone or online and in advance, up to four weeks in advance. The practice had a system in place for patients with a medical

Good

Are services responsive to people's needs?

(for example, to feedback?)

emergency and children and those more vulnerable to deteriorating rapidly were prioritised. All children under 5 were seen on the same day whenever possible regardless of whether the matter was urgent. We saw this in practice on the day of our inspection.

Home visits and telephone consultations were also available. A duty GP system was in use at the practice to review and assess urgent requests to see a GP.

The practice was aware of the different population groups and had a system in place to provide appointment times to meet their needs. This included consideration for the elderly and less mobile and for mothers with children of school age. This also included the length of the appointment and double appointments were available to patients with multiple health conditions were concerned or for patients with learning disabilities or long-term health conditions where more time might be needed to understand and explain care and treatment needs.

The practice had signed up to provide an additional service to patients at risk of an unplanned admission to hospital. These patients were provided with an alternative number to phone for an appointment if they required medical attention and were seen as a priority.

The practice monitored the numbers of patients who did not attend for their appointment. Patients who frequently did not attend were contacted and advised of the impact this had on other patients. The practice made use of text messages to remind patients of their appointment. This was reviewed monthly.

Data from the national patient survey published in July 2015 reflected that;

- 57% of patients were happy with the surgery hours compared with 72% locally and 75% nationally.
- 85% said that the last appointment they got was convenient compared with 90% locally and 92% nationally.
- 69% usually waited 15 minutes or less compared with 64% locally and 65% nationally.
- 40% described their experience of getting an appointment was good compared with 70% locally and 73% nationally .

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. 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. The complaints procedure was displayed in the reception area to inform patients.

Reception staff told us that patients wishing to complain were advised to do so in writing but if at all possible they would support a patient to resolve the complaint to their satisfaction. A note book was in use to record those complaints of a less serious nature that did not require a full investigation and analysis. Complaint forms were not available at reception for patients to complete but staff were aware of the procedures to follow and advised patients accordingly. A comments box was available in reception for patients to use.

Patients spoken to on the day of the inspection felt confident that any complaint they had would be investigated professionally. None of the patients we spoke with had ever needed to make a complaint about the practice. The practice had only received one complaint in the last 12 months, and we found this had been properly investigated.

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 statement of purpose. It described their aim to provide patients with personal health care of high quality and to seek continuous improvement in the health status of the practice population overall. Their statement of purpose stated that 'they aimed to achieve this by developing and maintaining a happy, sound practice which was responsive to people's needs and expectations and which reflected whenever possible the latest advances in primary health care.'

The practice ethos was to put patients first, deliver high quality care, the promotion of excellence and the achievement of quality outcomes for patients. The practice staff spoken with were aware of the vision and values of the practice and how their role affected it. Staff all had job descriptions that linked their role to the aims and objectives of the practice.

We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. They were kept informed of any developments through team meetings. They had been made aware of the planned move to larger premises and felt involved in the planning and development of this change. Minutes of meetings reflected that staff were involved in the future planning at the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff within the practice. Staff spoken with displayed an awareness of their contents. All policies were readily available in a practice policy folder.

We looked at several of these policies and procedures and found that they had been reviewed annually and were up to date. These included infection control, confidentiality, recruitment, data protection and duty of candour.

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

All staff at the practice had their own personal folder that contained relevant documents and policies to support them in their role. This included minutes of management and team meetings so that if away from work for a period of time they had ready access to any matter that required their attention or feedback from safety incidents, complaints and the general management of the practice.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. 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 or above national averages. We found that QOF data was regularly discussed with staff and action was taken to maintain or improve outcomes when required.

The practice also had an on-going programme of audits which it used to monitor quality and systems to identify where action should be taken. One example was an infection prevention and control audit that had been undertaken in May 2015. This identified some areas where improvements could be made and an action plan was in place to ensure progress was made. Dates had been recorded when actions had been completed. Clinical audits that took place included the management of patients with chronic heart conditions, steroid injections and their effectiveness and prescribing audits in relation to medicines identified from medicine alerts sent to the practice.

Leadership, openness and transparency

The lead GP at the practice and the practice manager provided visible leadership and staff told us that they were approachable and always had time to listen to all members of staff. Staff spoken with were aware of who to contact at the practice if they had an issue to raise. They said they were involved in discussions about how to improve and

Are services well-led?

Good

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

develop the practice. Staff told us that they were encouraged to identify opportunities to improve the service delivered by the practice, either at team meetings or informally.

Staff spoken with told us that the lead GP and practice manage managed the practice and staff effectively and they felt valued and part of a team. They were updated regularly on performance issues and where these might be improved.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients although they had been unable to form a Patient Participation Group (PPG) despite advertising it in the reception area and on their website. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The practice had a comments and suggestions box in reception.

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

providing feedback about the services provided at the practice service and to identify where they might improve.

The practice had produced a patient survey action plan for the year 2015. This included adopting an initiative to reduce the number of unfulfilled appointments, caused by patients failing to attend at their allotted time. Patients were now being offered on the day appointments on Monday mornings and Friday afternoons only. This was currently work in progress and the initial findings revealed that more patients had attended for their appointments releasing additional appointments at peak times.

One of the GPs at the practice had used an external company to obtain feedback from patients about their individual performance at the practice. A total of 34 patients had replied. Patients were asked to comment on the GPs politeness, whether they listened effectively, their explanations about their condition and treatment and many other areas. The results indicated that the majority of patients graded the GP as very good across all areas. There were no responses that reflected that patients were dissatisfied with any of the areas commented about.

The practice sought feedback from staff through staff meetings, appraisals and discussions. Staff told us they were encouraged to provide feedback and discuss any concerns or issues with colleagues and management. Staff made use of a comments book to record their improvement ideas and these were discussed with managers. One member of staff told us that they had asked for specific training around summary care records to ensure they were up to date with current guidance and this had been provided for them. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had started the NHS Friends and Family test and the results for the first four months of the year reflected that the majority of patients were either extremely likely or likely to recommend the practice. Data from the national patient survey from January 2015 reflected that 47% of patients would recommend the practice to someone new in the area and 70% described their experience at the surgery as good.

There had been no practice patient survey undertaken for some time and one was not planned for the future.

Management lead through learning and improvement

The practice had an ethos of learning that ran through their systems and processes at the practice. This included liaison with external agencies where a wider audience could benefit from identified learning.

Significant events, safety incidents and complaints were all analysed and investigated and where areas for improvement or learning had been identified, this was cascaded to staff at team meetings and informally.

The practice undertook clinical and non-clinical audits to assess and monitor the quality of their services and identified where and how they could be improved.

The practice used their appraisal system to identify learning and development opportunities for their staff and supported them whenever they were able. Staff told us that the practice was very supportive of training and said that the practice encouraged them to maintain their clinical professional development through training and mentoring. They told us that senior staff at the practice were prepared to listen, sought feedback and were willing to learn and improve.

Are services well-led?

Good

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

There was protected learning time where clinical and non-clinical staff were able to learn new skills, update themselves on legislation and guidance and attend relevant courses.