Church Langley Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Church Langley Medical Centre on 22 April 2015. Overall the practice is rated as good.

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

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.
- Risks to patients were assessed and well managed, with the exception of those staff undertaking chaperone duties.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they were able to make an appointment with a GP and the nursing team and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice was open and receptive to challenge, proactively seeking feedback from staff and patients, which it acted on.

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

Summary of findings

Importantly the provider should

- Ensure risk assessments are conducted for staff who carry out chaperone duties but have not been subject to a criminal records check to determine why one is not required.
- Improve their record keeping to ensure it is an accurate reflection of all decisions and actions taken.
- Ensure staff receive training appropriate to their role including the health care assistant responsible for use of the spirometer (a device used to monitor lung function) to improve the diagnosis of Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic symptoms.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed with the exception of non-clinical staff undertaking chaperone duties. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from 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. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams.

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy

Summary of findings

to understand and evidence showed that the practice responded quickly to issues raised. The practice conducted appropriate timely investigations into complaints and shared learning 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 governance meetings. 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. 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. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for frail patients and those with enhanced needs. Successive appointments were scheduled to monitor and respond to evolving patient needs. Unplanned admissions were actively monitored through the patients named GP and three monthly care reviews. Multidisciplinary meetings demonstrated co-ordinated and holistic care delivered through health/social care agencies and support groups and voluntary organisations.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice maintained and reviewed their chronic disease registers to meet the needs of patients such as conducting timely tests and annual reviews. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients had a named GP and access to onsite phlebotomy services to assist in informing their structured annual reviews to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals including, support groups and voluntary organisations such as the local stroke support groups to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice offered priority on the day appointments for children under 15 years of age and patients told us these were honoured. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations when compared to the national averages. Patients told us that children and young people were treated in an age-appropriate way and were recognised as

Summary of findings

individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Weekly antenatal and postnatal appointments were held at the practice and regular discussions, referrals and joint working was conducted with the paediatric nursing team providing advice and guidance to patients.

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. For example the practice offered extended opening in the morning providing consultations at 7am to assist patients commuting into London. The practice also offered telephone appointments and electronic prescribing with plans to introduce online appointments with the introduction of new patient record system in the summer of 2015. The practice also provided a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access appropriate support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. 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.

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 maintained a mental health register, patients were invited to attend annual physical health check and scheduled four to six week follow up appointments to monitor and respond to their evolving needs.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including referring patients to the Crisis Mental Health teams, psychiatry, counselling and various support groups and voluntary organisations including MIND.	

Summary of findings

What people who use the service say

We reviewed the findings of the National Patient Survey 2015 for which there were 110 responses from the 325 questionnaires distributed to patients; a response rate of 34% of those people contacted. The practice performed above average within their Clinical Commissioning Group in relation to the care provided by the practice nursing team, in particular; respondents saying the last nurse they saw or spoke to was good at involving them in decisions about their care, that the nurses were good at listening to them and explaining the tests and treatments. However, the practice performed just below the Clinical Commissioning Group average for respondents with a preference to see or speak to a GP getting to see them; patients usually having to wait 15 minutes or less after their appointment time to be seen; and for patients recommending the practice to someone new to the area.

We reviewed patient comments on the NHS choices website. The practice had considered all previous criticisms of patients recorded on the website. They accepted that they had previously failed to be accessible and responsive to their patient needs due to difficulties with staffing, due to bereavements and illness. This they had explained to the Patient Participation Group (PPG) and were actively recruiting to all positions within the practice to ensure in the future they could better meet the needs of their patients. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

We provided the practice with comment cards ahead of our inspection and invited patients to complete them so we may capture their experiences of the service. We received 19 completed Care Quality Commission comment cards. These were positive about the care patients received. Patients told us staff were friendly, polite and helpful to them. They understood they had confidence in the clinical team and were happy to see them for assessment and treatment.

We spoke to health professionals who worked with the practice such as the district nursing and health visitor team. They told us they had a good working relationship with all members of the practice team. The practice responded in a timely and appropriate way to requests for information and was actively engaged in providing good end of life care to patients.

We spoke with eight patients on the day of our inspection they told us that the staff were polite and helpful. They were consistently good at seeing children at short or with little notice but delays were experienced for adults who worked and needed appointments. They understood the surgery triage system for patients requiring appointments at short notice and believed if they required urgent clinical attention they would receive it.

Areas for improvement

Action the service SHOULD take to improve

- Ensure risk assessments are conducted for staff who carry out chaperone duties but have not been subject to a criminal records check to determine why one is not required.
- Improve their record keeping to ensure it is an accurate reflection of all decisions and actions taken.
- Ensure staff receive training appropriate to their role including the health care assistant responsible for use of the spirometer (a device used to monitor lung function) to improve the diagnosis of Chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic symptoms.

Church Langley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Church Langley Medical Centre

The Church Langley Medical Practice is located in a purpose build medical centre shared with other health professionals such as dentistry. The building is owned by Harlow Health Centre Trust which is responsible for the maintenance of the building. It is situated in the heart of a large new housing development in Church Langley situated near Harlow and with easy access into London via the M11. Phase 2 and 3 of housing is being built and soon to be populated principally with young families and their children. There is limited capacity for the practice to expand to meet the increasing demand on services from people moving to the area.

The practice holds a General Medical Service contract. This is the type of contract the practice holds with NHS England to provide medical care to patients. It has 10,600 patients registered with the practice, with a quarter of their patient population under 15 years of age. The practice has three partner GPs, due to increase to four by the end of May 2015. They have two salaried GPs and a nursing team (including a health care associated practitioner and phlebotomist) and an administrative/reception team.

The practice has a comprehensive website providing a wealth of information for patients to understand and access services, including useful links to specialist support services.

The practice has opted out of providing out-of-hours services to their own patients. Emergency medical attention between 6:30pm to 8am weekends and bank holidays are provided via the NHS 111 service.

Why we carried out this inspection

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

Comprehensive inspections are conducted 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

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?

Detailed findings

- Is it well-led?

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 April 2015. During our visit we spoke with a range of staff from the practice manager, administrative and receptive staff and the clinical team consisting of the GPs and practice nurses and spoke with patients who used the service. We talked with carers and/or family members and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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. We reviewed the practice policy on the reporting of injuries, disease and dangerous occurrences, which clearly set out for staff the reporting arrangements. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed the practice accident book and found two entries from July 2014 both relating to accidental needle stick injuries. One of the incidents was referred and examined as a significant incident and the other incident was discussed during a partners meeting and raised as a training and development need for the member of staff. This showed the practice had managed risks and learnt from them and 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, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review all 17 reported incidents. These included issues such as a break in cold chain for childhood immunisations that may have compromised the integrity of the medicine, pharmacy errors, the deterioration of a patient's health whilst at the surgery and needle stick injuries. Significant events were reviewed quarterly although immediate actions were always taken and documented on receipt of the allegations. There was evidence that the practice had learnt from these incidents 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.

Staff used incident forms on the practice computer system or completed them manually and provided the form to the senior administration. We were shown the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner and evidence of action taken as a result. For example, following receipt of an allegation of a break in cold chain of childhood immunisations on 25 September 2015. An investigation was initiated by the practice manager the following morning and all staff were asked to account for their role and responsibilities in relation to the incident. The investigation was concluded on 1 October 2014. The senior GP partner oversaw the initial investigation and ensured all staff were spoken with regarding the outcome of the investigation and learning was shared to mitigate the risk of a reoccurrence. The event was also re-examined in the December 2014 significant incident meeting to check changes had been embedded into practice. 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 and Medicine Health Regulatory Agency information were disseminated by the practice administrator to the clinical team and the practice staff. The copies were stored for staff reference on the practice computer system, in a manual file and a specific alert folder. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. We saw a medical device alert the practice had received on the morning of our inspection. The alert related to the appropriate use of safety belts fitted to supportive seating such as wheelchairs and hoists. The practice manager explained how relevant alerts were discussed during multidisciplinary team meetings to ensure shared learning with their partner services. The practice also searched their patient records to identify those who may have mobility issues and may benefit from the information on their next attendance at the practice.

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 were easily accessible.

Good

Are services safe?

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. All non-clinical staff had undertaken vulnerable adult and children safeguarding training and were aware who the clinical lead was and who to speak with in the practice if they had a safeguarding concern. All clinicians were scheduled to attend refresher training on 29 April 2015 to ensure they had been trained to a sufficient level.

There were chaperone signs advertised in some clinical consulting rooms. (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). All the clinicians knew who the chaperone trained staff were, these consisted of both clinical and non-clinical staff. All staff had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination and to ensure an entry was made into the patients' medical record to state a chaperone was present throughout the consultation/examination. Not all non clinical staff who had undertaken chaperone responsibilities had been risk assessed as to why they may not require a criminal records check.

There was a system to highlight vulnerable patients on the practice's electronic records. GPs were appropriately using the required codes on their patient records to ensure risks to children and young people who were looked after, on child protection plans or were vulnerable patients were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as social services through the practice monthly multidisciplinary meetings. These meetings were well recorded and were also considered beneficial for staff to share concerns and follow up on issues such as children who persistently failed to attend appointments e.g. for childhood immunisations. The practice nurses also received additional information from child health visitor to identify children who had missed immunisations.

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 described the action to take in the event of a potential failure. The practice staff followed the policy.

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.

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 practice had a policy to not hold controlled drugs. (Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.)

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. We noted that the GPs locked their rooms when unattended to ensure the security of information and equipment.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. However, the schedules were not dated to enable the practice to know exactly which items had been cleaned, when and by whom. The practice did not have a separate cleaning schedule for the minor surgery room, where the potential risks of infection for the patients were greater. However, patients we spoke with on the day 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. All staff received induction training about infection control specific to their role and were issued a copy of the practice infection control policy. We saw evidence that the lead had carried out an audit for the last year on 16 April 2015. Actions were identified, but there was no action plan documented defining who was responsible

and when the issue would be resolved. However, when we spoke with the practice manager, they were able to tell us all actions taken to resolve issues identified and proposed dates for resolution.

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. For example, 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. Clinical and non-clinical staff were also offered Hepatitis B injection to mitigate them against the risk of infection.

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 and consultation rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed Harlow Health Centre Trust, as owners of the building had conducted the checks in April 2014. Regular checks were carried out to reduce the risk of infection to staff and patients.

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. The practice conducted visual checks on electrical equipment and had scheduled their portable electrical equipment to be routinely tested in May 2015. The practice last calibrated their equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer in June 2014 and was next scheduled for May 2015.

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) for clinical staff. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. DBS checks were not conducted for non clinical staff including those who conducted chaperone duties.

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. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this provision written in their contracts.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment, concerns relating to the building are escalated to Harlow Health Centre Trust. The practice also had a health and safety policy. The lead GP partner and the practice manager lead on all health and safety matters, and guidance was provided to staff within their handbook on health and safety at work.

The practice had identified risks and these had been discussed and mitigation measures introduced. For example, the practice had identified that staff were not dual trained in roles and they had over dependence on people to conduct roles. Staff had since been trained in several roles to build resilience and sustainability in services.

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

Good

Are services safe?

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. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being of patients or medical emergencies.

We reviewed the practice's significant event meetings notes and found staff had raised an incident where a medical emergency concerning a patient had occurred. Staff actions had been reviewed and practices amended demonstrating appropriate learning from the incident. For example, staff would speak with and/or message the GPs to inform them of concerns relating to a patient's health deteriorating, to secure a timely response.

Emergency medicines were available in a secure clinical area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. (Anaphylaxis is a sudden allergic reaction that can result in rapid collapse and death if not treated.) 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.

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 although some were incomplete. We also found some of the practical considerations would benefit from being revisited. For example, ensuring staff had access to the patient record system off site and the availability of alternative site locations.

The practice had a fire risk assessment check list that included actions required to maintain fire safety. The practice was reviewing systems and updating their risk assessments and procedures. The practice had three designated fire wardens in addition to all staff being trained in evacuation procedures. All fire alarms had been tested monthly and were conducted by the building owners Harlow Health Centre Trust. The practice had scheduled in their annual fire evacuation drill for staff.

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. 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 led in specialist clinical areas such as; diabetes and asthma and the practice nurses/health care assistant supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. We found staff understood their roles, responsibilities and professional limitations.

The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices a year ago. We found that the practice actively monitored their monthly referral rates to other services individually and as a practice. They also sent a practice representative to the CCG referral review meetings. At which the appropriateness and trends in referrals were discussed, lessons learnt were identified and disseminated to all staff to improve practice.

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.

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. In addition the senior administrator conducted additional governance checks on additional software which enabled the practice to interrogate the data to identify anomalies. Where patients had not received appropriate screenings these were followed up to ensure the patient could access appropriate services.

We reviewed the data from QOF for 2013/14. We found that the practice was performing similar to other practices both locally and nationally in several areas. For example data showed that the practice had a lower number the national average of people with one or more long term condition.

From the QOF data 2013/14 we saw that the practice performance was lower than the national average for reviewing and monitoring patients who had diabetes to ensure that risks associate with this disease such as kidney failure were monitored and that their treatments were effective.

The practice showed us five clinical audits that had been undertaken in the last 18 months. The lead GP told us they often obtained the audit ideas from local guidelines, the CCG or where they may be performing as an outlier. For example, the practice recognised that they had a small group of patients who were on a combination of medicines that were discouraged. Nine patient cases were identified and clinical reviews conducted of these. By doing so, the practice was able to amend the patient medicines to a safer prescription. The practice also reviewed how they responded to patient safety alerts and their use of the IT system to flag alerts to clinicians during consultations.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit from September 2014 where the practice revised all controlled drug prescriptions for that month to ensure they were safely prescribing. We found adjustments had been made by the practice resulting in a reduction in prescribing. (Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.)

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had historically low performance for meeting the needs of patients with diabetes, in particular in objective measures such as blood pressure and cholesterol control. This had been recognised by the practice who attributed their performance as due to inconsistent availability of clinical staff. Thereby presenting them with difficulties in delivering continuity of care, especially in the absence of a clinical lead, poor data recording and other patient factors such as working age people who failed to engage with daytime clinics. Following this, the practice proactively addressed this and most recent QOF data had shown an improvement. The practice believed was sustainable, due to now having an appointed clinical lead, regular diabetes clinics and co-operative working with the diabetes nurse. We reviewed clinical meeting minutes and saw that the practice performance was reviewed and actions taken where the practice was failing to meet the full clinical criteria such as the taking of patient blood pressure.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register with eight patients listed. They held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. For example, every fortnight the healthcare assistant telephoned patients on the palliative care register to conduct a welfare check, providing a proactive and accessible service to meet their evolving needs. This was undoubtedly aided by the healthcare assistant's interest and professional background in end of life care and had been well received by patients. For those patients who did not wish to receive this service, their wishes were respected.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. A recently appointed GP told us how they had been well supported through a structured induction programme to meet the practices' and their own individual needs. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with GP's having specialist interest and lead areas such as minor surgery, mental health and palliative care. All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented with the exception of the practice manager who had not had an appraisal. We reviewed three appraisals of clinical and non-clinical staff and all staff had been invited to comment on their performance, followed by a discussion with a clinical or line manager. However, it was not apparent what objectives the staff member was being assessed against. We found there was reference to training being available, but it was not aligned to any business or personal development plan. Where issues or concerns were raised by the staff member it was not always clear how these had been resolved. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the

practice had encouraged the attendance of a practice nurse at a GP training day. At the time of our inspection the practice did not maintain a documented training and development overview to ensure the programme could be delivered.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on the administration of vaccines, and were also able to demonstrate that they had appropriate training to fulfil these roles. However, we found the healthcare assistant was responsible for use of the spirometer, a device used to monitor lung function. The staff member had not received formal training, but had been shown how to operate the equipment by other clinical staff. Specific spirometer training is advocated for staff in order to improve the diagnosis of Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic symptoms.

The practice had not had to manage poor performance of staff. The practice manager told us should they experience poor performance by a member of their staff they would initially seek to support the staff member through training and development prior to initiating capability proceedings.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support patients with more 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. However, the practice had experienced delays receiving information and consequently had to put a reliance on the patients notifying them. This had been escalated to CCG quality board to address as a priority and the practice awaited a response.

The practice had outlined responsibilities for all practice 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.

The practice was commissioned for unplanned admissions, an enhanced service of which they had identified 2.8% of their patient population eligible for the programme (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). This required the practice to conduct regular reviews of the patients care plans and to mitigate the risks of their unplanned admission to hospital.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs, for example, those patients with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses, frailty nurse and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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 made referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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, but had experienced a range of difficulties with its reliability. The system would often be inaccessible resulting in staff having to operate a manual paper system in the interim and then retrospectively updating patient records. During this time, clinicians were unable to electronically approve prescriptions or receive electronically transmitted test results. Therefore, the practice had decided to transfer to an alternative electronic patient system during the summer of 2015. This was intended to offer their staff and patients greater reliability whilst also linking in better with partner

Good

Are services effective?

(for example, treatment is effective)

services such as the community nursing team and healthcare assistants who used the same system. Both software systems enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff we spoke to were aware of individual patient needs that may need to be considered, such as where a patient may have learning disabilities. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). They explained to us about the differences in obtaining verbal implied consent and the need to formally recorded consent.

The practice had a define process 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.

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

Health promotion and prevention

The practice did not offer new patient checks for patients newly registered with the practice. However, NHS health checks such as those for 40 to 75 year olds were offered with the healthcare assistant. 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, we were told by the healthcare assistant how during a health check they identified a patient with poor mental health who was immediately referred to the GP for specialist clinical input and support.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability, the 21 patients of the register had been offered an annual physical health checks and non-attendance was followed up.

The practice told us of how they were working with the paediatric nurses who had been invaluable at providing practical and accessible health information to young parents and over the weekends. Their attendance at the practice monthly multidisciplinary meetings was also valued in particular their input into safeguarding concerns.

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 for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice had appointed named GPs for patients over 75 and held monthly multidisciplinary meetings, which were well attended and considered effective by staff. We spoke with the practice district nursing team who told us of the practices willingness to share information with them and their interest and commitment to delivering good end of life care. This was evident in the patients individualised care plans and the practices commitment to identifying and responding to patient needs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the findings of the National Patient Survey 2014 for which there were 110 responses from the 325 questionnaires distributed to patients, a response rate of 34% of those people contacted. The practice performed above average within their Clinical Commissioning Group in relation to the care provided by the practice nursing team, in particular; respondents saying the last nurse they saw or spoke to was good at involving them in decisions about their care, that the nurses were good at listening to them and explaining the tests and treatments. However, the practice performed just below the Clinical Commissioning Group average for; respondents with a preference to see or speak to a GP getting to see them, usually having to wait 15 minutes or less after their appointment time to be seen and for patients recommending the practice to someone new to the area.

We reviewed the most recent data available for the practice on patient satisfaction. The practice conducted a survey of their patients in January 2015 and found 78% of the patients surveyed told them the GP was good at treating them with care and concern. Patients reported their overall experience of the practice remained similar to the GP National Patient Survey results 2013, but beneath the national average of 82%. The practice told us they were disappointed by these findings as they did not feel they were reflective of the changes they had and continued to make in order to better serve their patient needs.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 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. We also spoke with eight 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However, this was difficult given the reception desk was exposed to the main waiting area. We saw no sign displayed advising patients of the opportunity to speak with staff privately. There was a line drawn across the reception floor to encourage patients to stand back from the desk and observe the privacy of others. The reception staff told us they did advise patients to stand back whilst others are at the desk. We also noted that the waiting area chairs were faced away from the reception; this was intended to reduce patients overhearing conversations at the desk. However, it also reduced the potential of staff identifying where a patient's health may deteriorate.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

The practice and their staff had zero tolerance for abusive behaviour. They told us how they had removed a patient from their register due to consistently poor and inappropriate behaviour. This had been conducted in partnership with NHS England Area Team to ensure the patient could still access health provision.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed 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, data from the Patient Participation Survey 2013/2014 showed

that 86% of patients asked rated the GPs as good or very good for involving them in care decisions and 92% of people believed they were given sufficient time by the GP. The GP National Survey also supported the practices'

Good

Are services caring?

findings with 92% of the patients asked stating the last nurse they saw or spoke to was good at involving them in decisions about their care. This was above the national average of 85%.

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.

Staff told us that translation services were available for patients who did not have English as a first language. However, we saw no notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The National GP Survey information we reviewed for January 2015 showed patients consistently rated the care they received from the nursing team as high. For example, 94% said the last nurse they saw or spoke to was good at treating them with care and concern and all reported that they had confidence and trust in the nurse. However, the levels of patient satisfaction with the GPs was lower with 73% of patients commenting that the last GP they saw or spoke to was good at treating them with care and concern. Patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when patients needed help and provided support when required. Some GPs were particularly well regarded by patients.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and a bereavement card would be sent. This was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had arranged to speak with NHS England regarding their funding arrangements as, at the time of our inspection; their funding was weighted on a patient population of 7,500, despite providing services to 10,600 patients. A quarter of their patient population was also under 15 years of age placing additional demands on the accessibility of the service. This was recognised by the practice partners as presenting a challenge to implementing service improvements and meeting the needs of a growing young patient population.

The practice told us of their concern following the results of the 2012 GP National Patient Survey where the practice was identified as have poor patient access. The practice had revised their systems in response and in addition to appointing to GP vacancies had introduced a telephone triage system. This had been especially effective at managing the high patient demand for appointments with GPs on Monday mornings. The calls were always triaged by a GP as the practice had found this to be more timely and clinically effective then when previously conducted by a practice nurse. Patients also reported more confidence in the system and were more acceptant when signposted to an alternative clinician such as a nurse. However, this had not been well received by all patients, and some patients objected to disclosing the reason for their appointment to reception staff to enable them to be triaged. This was respected by the practice who placed the patients name on the call back list and ensured a clinician called them back to discuss their concerns.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, GPs were now able to schedule follow up appointments which had been appreciated by patients, reducing the anxiety and inconvenience of having to separating schedule an appointment time.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had an automatic check in system which was available both in English and Polish meeting the needs of their growing polish patient group. Although we found no information available in different languages. The practice told us currently their patient group were confident in communicating in English but they acknowledged a growing need to ensure they are meeting the evolving needs or a multicultural community

The practice had previously had access to online and telephone translation services but this was no longer available through the CCG. This issue had been raised with the CCG, by the practice, and they were awaiting a response. However, the patients benefitted from some staff being conversant in some African and Indian languages, as well as French and Spanish.

The practice did not provide equality and diversity training to their staff. We saw staff were polite and listened and responded to patients appropriately. Although due to the exposed nature of the reception area clinical information could be overheard on occasions. This had been recognised by the PPG in the past and discussions held with the practice regarding how this may be minimised. However, the practice was restricted by the physical layout of the building presenting few alternative means of arranging the reception area to minimise the intrusion.

The premises and services had been adapted to meet some of the needs of patient with disabilities. The practice was situated on the ground floor of a purpose built health centre with electric opening entrance doors. We saw that the waiting area was restrictive, but sufficient to accommodate their patient numbers. The reception desks were not lowered to enable people in wheelchairs to converse comfortably with staff. There was no provision for people with impaired hearing and no literature available in larger text. The practice did not have sufficiently wide corridors for patients with mobility scooters, or prams and pushchair to navigate through. There was only one toilet facility available. The accessible toilet had been deemed

Good

Are services responsive to people's needs?

(for example, to feedback?)

unsuitable for use and there were no baby changing facilities. Both issues had been reported to the building landlords several months previous and the practice were still awaiting a response.

We spoke with patients regarding their experiences of the service. A patient told us they received an accessible and caring service to meet their mental health needs. They were always able to see a GP with whom they had a good and supportive relationship with minimum notice. Although, they experienced frustrations with their access to secondary care and support with supplementary services.

Access to the service

Appointments were available from 7:30am to 6.30pm on weekdays and an earlier start on Thursday at 7.15am. The reception operated from 7:30 where required to facilitate early appointments to 6:30pm and fully engaged with the extended hours enhanced services schedule. This was principally achieved by opening early to meet the needs of commuters into London. Urgent appointments could be made on the day but were subject to triage by the duty doctor. On the day of our inspection we found patients were required to wait four weeks for a pre bookable appointment with a GP and four days with a practice nurse. Although, patients could call on the morning for available appointments. The practice was committed to enhancing their availability of routine appointments from 370 in 2014 to 558 in 2015 on the appointment of the fourth GP partner and two salaried GPs. This was to be supported by an enhanced clinical team of two practice nurses, a specialist care assistant and two healthcare assistants.

Comprehensive appointment information was available on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the telephone system including when the practice was closed. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a GP or nurse. Patients told us that the practice was responsive to the needs of children and they could obtain on the day appointments for them at little notice. They also told us that the childhood vaccination and immunisation programmes were accessible and convenient. Patients presenting with poor mental health were also provided longer appointments and scheduled appointments in advance. This provided patients with additional reassurance and enabled clinicians to monitor and respond to their patients' individual needs in a timely and appropriate manner.

Some working age patients expressed some dissatisfaction with the appointments system. The parents of a child and a working age person reported difficulty accessing appointments, with a waiting time of two or more weeks. One patient reported embellishing the severity of their symptoms to enable them to secure a clinical face to face appointment with a GP as opposed to receiving health advice over the phone or being referred to a nurse. The practice had responded to some of the patients' concerns relating to accessibility and were constantly reviewing their performance in response to both national and local patient survey data and comments

The practice did not provide online booking of appointments. This was scheduled to be introduced in the summer, 2015. This would be available when the practice changed its electronic patient record system.

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.

We could not find information available to help patients understand the complaints system. Patients we spoke with were not aware of the complaints process to follow if they wished to make a complaint although none of the patients we spoke with had ever needed to make a complaint about the practice. The practice told us their preference was to resolve issues on the day, to avoid patients feeling the need to formalise them. For example, a patient told us that when they had raised concerns the practice had looked into them and provided an explanation prior to them leaving the surgery. They had confidence in the practice and felt their concerns had been listened to and responded to appropriately.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at six complaints received in the last 12 months and found all were satisfactorily handled, dealt with in a timely way. There was openness and transparency with dealing with the complaints. These related to allegations of appointments over running and causing delays, delays in receiving prescriptions and dissatisfaction with clinical diagnosis. However, in all cases we found the practice had conducted timely and appropriate investigations and in some cases additional audits to identify if the patient had previously been disproportionately affected by the actions of staff. Apologies were provided by the practice where appropriate and the practice accepted and implemented changes to improve communication with patients and staff.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy although this had not been formalised. The lead GP told us of their aspirations for the practice to become a teaching practice for both graduate and undergraduate medical students. The practice already had two GPs who had successfully completed the associate training course. The practice had also specifically asked potential candidates for partnership with the practice to explain their vision of practice and ensured it was consistent with the collective objectives of the management team.

We spoke with members of staff and they all knew and understood the challenges the practice had faced and the practice teams commitment to provide a strong and competent practice to meet their patient needs.

Governance arrangements

The practice held weekly partnership meetings every Wednesday afternoon attended by the practice partners and practice manager. These were used to review business risks and performance, and minutes were kept, revised and agreed.

Meetings were also held with the reception team and to review clinical cases. We looked at clinical meeting minutes from the last three months and found that performance, quality and risks had been discussed. For example, changes in clinical guidelines had been discussed including the implication for staff and patient referral processes.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for infection control and safeguarding and the responsibilities were clearly defined. We spoke with 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. They all valued a period of greater management stability.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. (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 QOF data for previous years showed the practice was not consistently performing in line with national standards. This was known to the practice who had attributed their previous poor performance to personnel difficulties relating to bereavements, high use of locum doctors and the loss of their practice manager. The practice had responded positively to all the challenges and, at the time of our inspection, had a core clinical team in place designed to deliver consistent and accessible care to patients.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The practice manager told us they were responsible for maintaining all of them. They reviewed them annually on a rolling programme and as and when legal or procedural changes occurred. They did not retain evidence that staff had read and understood them. However, had identified this as an area for development.

The practice participated in the local referral peer review system operated within the CCG. This was designed to discuss and ensure the timely and appropriate use of referrals. We saw how each practitioner's referrals were monitored internally and externally against other similar sized practices to identify potential anomalies in referral rates. Where differences in referrals existed the practice were aware and were able to explain why they had occurred and that they were appropriate for the patient.

The practice had a range of both formal and informal arrangements for identifying, recording and managing risks. The lead GP and practice manager acknowledged that staffing presented their greatest reputational and financial challenge and risk to their business. The practice told us how they had advertised on three occasions for appropriate GP partners prior to their successful appointment. A process they found both expensive and time consuming, but essential in order to enhance the accessibility of the service. However, these risks were not formally documented but known to partners and discussed.

Leadership, openness and transparency

We saw strong leadership by the lead GP who worked closely with the practice manager. They were open and honest about the challenges the practice had and continued to face. They had arranged to speak with NHS

Are services well-led?

Good

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

England regarding their funding relating to the weighting of patient numbers. The practice explained how they were currently funded for 7,500 patients due to their demographic being young. However, they were delivering services to 10,600 patients. They told us how this presented difficulties in ensuring an accessible service especially as priority appointments were given to children under 15 years accounting for a quarter of their patient base. They saw these difficulties were only to increase with further new housing developments attracting a young patient group into the area.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted during our inspection that clinicians were happy to seek a secondary medical opinion from their peers. This demonstrated openness and willingness to learn and improve practice to the benefit of both patients and colleagues.

The practice manager was responsible for human resource policies and procedures. The practice had a comprehensive staff handbook and staff contracts of employment. These addressed all aspects of their employment such as disciplinary procedures, induction policy, management of sickness which were in place to support staff. Each staff member was issued with a manual staff handbook and a copy was electronically available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies, if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through their January 2015 practice survey. These they distributed both manual copies and via email. 200 paper surveys were handed to patients on attending the practice and 60 emailed. The practice reported an exceptionally low response rate via email. This surprised them given the high number of patients who commuted and they believed would have preferred to engage with them via electronic communication. 93 patients responded overall and their comments were overwhelmingly positive with 90% of them reporting having confidence and trust in their GP. Access was still raised as a concern and as a result of this the practice responded by increasing their recruitment of staff at all tiers of the organisation. They had appointed more GPs to increase their clinical appointment capacity and increased the number of receptionists, reception staff and clerks to enable staff to focus on their roles. The lead GP and practice manager were open and honest and stated that the accessibility of appointments was subject to daily reviews and they encouraged and supported staff to be flexible with access and escalate concerns to management team if they were unable to resolve the issue and thereby ensuring patients' voices were heard and they received timely clinical care.

We spoke with two members of the PPG. 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 PPG was in its infancy since being reformed after an 18 months break following poor communication and commitment by the practice. The PGG told us they believed the practice was committed to being the best they could be and delivering good and consistent care to their patients. They acknowledged the new commitment of the practice to the process and welcomed discussion and receipt of new terms of reference defining their role and responsibilities. They emphasised the need for the practice to improve communication with them and were considering the best means of achieving their objectives such as via a virtual group for potentially surveying patient opinions.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt more involved and engaged in the practice to improve outcomes for both staff and patients since staffing had stabilised. We reviewed clinical meeting minutes and saw how concerns raised by the nursing team relating to the length of clinical consultation had been discussed and action had been taken to improve the scheduling of more time for more complex interventions such as the dressing of wounds and stitch removal. The nursing team had also raised concerns regarding their ability to fully engage with the meetings due to appointments often preventing them attending for the full duration. The practice acknowledged the importance of their attendance at the meetings and ensured they had protected time to attend and therefore feed into decision making processes.

Are services well-led?

Good

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

The practice told us and proudly advertised their participation and achievements as a research practice. The practice actively encouraged staff to engage in further research and this was evidenced in personal appraisals and development plans. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that clinical staff are invited and encouraged to attend monthly educational meetings. The content of the meeting varies and may be delivered by in house clinicians or external clinical speakers. Recent presentations had been made in respect of; diabetes updates, asthma updates, stroke support updates, gynaecology management, rheumatology management and orthopaedic management. The sessions had been arranged to enhance practitioner awareness of changes in clinical practice and services available to patients. The training opportunities had been well attended and received by clinicians who valued the opportunity to listen and learn about services.

The practice also conducted two annual shutdowns of the practice when all non-clinical staff were provided with an opportunity to receive training updates, address issues and make suggestions relating to the practice management and systems. The lead GP told us they were currently reviewing proposals for the next event and were considering revisiting the management of patient information and confidentiality.

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