The Cedars Surgery

Quality Report

26 Swanley Centre
Swanley
Kent
BR8 7A
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Website: http://www.cedarssurgeryswanley.co.uk/

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Cedars Surgery on 7 October 2014. During the inspection we gathered information from a variety of sources. For example; we will spoke with patients, members of the patient participation group, interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice is rated as good. This is because 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 care of older people, people with long term conditions , families, children and young people, the working-age people, of people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

Our key findings 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.
- People's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs have been identified and planned.
- 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.
- 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 to understand.
- There was a leadership structure and staff felt supported by management. There was an active patient participation group.

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

Summary of findings

Importantly the provider should

- Improve the quality of record keeping in relation to training to ensure effective monitoring and updates are undertaken and completed in a timely manner.
- Ensure that contingency planning, triage by receptionists and management of medicines are supported by documented protocols and processes that all the staff can work to and recognise.
- Improve the quality and timeliness of clinical governance arrangements.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. We saw that arrangements were in place to ensure safe patient care. There was an effective system to learn from significant events, accidents and incidents. There were safeguarding procedures to ensure patients were safeguarded against the risk of abuse. We found there were appropriate arrangements for managing medicines. The practice was clean and there were effective systems to minimise the risk of healthcare associated infection.

Are services effective?

Good

The practice is rated as good for effective. There was evidence of effective assessment and diagnosis. Care and treatment was delivered in line with best practice guidelines including those from the National Institute for Health and Care Excellence (NICE). There was evidence of clinical audit across a range of activity. Staff were able to develop skills through training and appraisal, though sometimes records did not fully reflect this. Staff were aware of the importance of working with other services to achieve the best outcomes for patients. There was a wide choice of health promotion material both on paper and web based.

Are services caring?

Good

The practice is rated as good for caring. All of the patients we spoke with or who provided feedback were complimentary about the care they had received. We saw and heard staff were caring, compassionate and considerate. Patients said that they had enough information and time with the GP or nurse to meet their needs and that treatment was explained to them.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. There was access to GPs and nurses particularly when patients had urgent problems. There was a clear complaints policy. Comments and complaints were acted upon to improve the service. There was patient participation in the practice including a patient survey and a patient participation group.

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

Summary of findings

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

What people who use the service say

During the inspection we spoke with four patients. They were pleased with the quality of the care they had received. They all said it had been easy to make appointments with a GP and that they were seen at, or close to, the time of their appointment. No comment cards were completed by patients at the practice.

We asked the practice to announce the inspection on their web site and to give an email contact for the inspector so that patients and staff could send in comments. The practice did this but we received no comments.

The practice carried out a patient survey. Two hundred and ninety eight patients responded. The main issues raised were

Queues in the waiting room

The provision of late appointments for commuters

The décor and the seating in the waiting room

Problems in getting through on the phone

Not enough appointments

The check in machine not working

The practice had acted on the results of the patient survey and had an action plan to deal with the issues the survey had highlighted. Actions taken so far had included; a new automatic check in machine, improvements to the decoration of the waiting area and extending the use of text messaging to remind patients of their appointment times.

Areas for improvement

Action the service SHOULD take to improve

- Improve the quality of record keeping in relation to training to ensure effective monitoring and updates are undertaken and completed in a timely manner.
- Ensure that contingency planning, triage by receptionists and management of medicines are supported by documented protocols and processes that all the staff can work to and recognise.
- Improve the quality and timeliness of clinical governance arrangements.

The Cedars Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised a CQC inspector and a GP specialist advisor

Background to The Cedars Surgery

The Cedars Surgery is located in a town centre. There is ample parking nearby. The surgery has six consulting rooms and two treatment rooms. The practice has a list of about 9300 patients. There are two partners. There are two male and four female GPs. There are three practice nurses, all female. The practice provides 30 GP sessions and 18.5 nurse sessions each week. The practice is not a training practice. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from

26 Swanley Centre

Swanley

Kent

BR8 7AH

The practice has opted out of providing out-of-hours services to their own patients. Information is available to patients about how to contact the local out of hours services.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining "good practice" in their surgeries.

We asked the local clinical commissioning group, NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced on the practice website and people were asked to send their comments to the CQC lead inspector whose e-mail address was provided. We placed

Detailed findings

comment cards in the surgery reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 7 October 2014. During our visit we spoke with a range of staff including; GP partners and salaried GPs, nursing staff, receptionists and administrators. We spoke with patients who used the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

Staff we spoke with said that there was an ethos at the practice where anyone could report concerns. They knew who significant events should be reported to. We saw that safety concerns were reported, recorded and actioned within the practice.

We saw there was a process for dealing with safety alerts. These were sent to individual GPs using the NHS network. Although there was no system for checking they had been read by each GP, we saw that a safety alert from March 2014, relevant to general practice had been received and dealt with properly Staff had received a presentation, from a member of the patient participation group, on dementia, this included recognising abuse in older patients and how to escalate any concerns.

Learning and improvement from safety incidents

The practice has a system for reporting, recording and monitoring significant events. We looked at the records of significant events.

There was learning from significant events. We looked at an incident where a member of staff had failed to refer a concerning rash to a doctor immediately. There had been a thorough investigation. Appropriate action had been taken and lessons learned were discussed at various levels within the practice. In another incident a housebound patient kept receiving letters requesting them to make an appointment to attend the practice. As a result of the investigation the practice implemented a more robust system to ensure that housebound patients' notes were adequately "flagged".

Reliable safety systems and processes including safeguarding

Patients we spoke with said that they felt safe at the practice. The practice offered a chaperone service where a member of staff would be available to accompany patients during examinations at their request (or at the request of the examining GP or nurse). We saw notices in the waiting area and in consultation rooms to that effect. Reception staff were used for chaperoning. We saw that there were seven trained chaperones. This was sufficient to ensure that chaperones were available if requested.

There was a GP lead for safeguarding vulnerable adults and children. All the GPs were trained up to the appropriate level (level 3) for safeguarding children. Almost all GPs and nursing staff had up to date safeguarding training in both adult and child protection though for two nursing staff there was no record of recent safeguarding training. For administrative staff five of 18 had no record of safeguarding training. These included three new staff. All the staff we spoke with knew who the lead for safeguarding was and how they would refer a safeguarding concern.

Medicines Management

We saw that there was a comprehensive policy for repeat prescribing. We spoke with a GP who confirmed that the practice had a system for checking that repeat prescriptions were issued with reference to the medicine review date for each patient. Repeat prescriptions were handed into the practice, to any of the local pharmacies or received electronically. They were not accepted over the telephone. The lead practice nurse checked that the medicines were authorised for the patient and whether the patient needed a medicines' review. If the medicine was not a repeat the nurse could generate new prescription for the patient and send a note (on the internal computer system) for the relevant GP to check and authorise, or not, the new medicines. This system, though effective and safe, was not supported by clear guidelines or protocols and in some areas the audit trail for decision making was weak.

Cleanliness & Infection Control

The practice had an infection control policy, which included procedures and protocols for staff to follow, for example, hand hygiene, clinical waste, and personal protective equipment (PPE). We saw that there was instruction on hand washing and the use of PPE in the consulting and treatment rooms. Staff we spoke with told us about the infection control policy and their own role with regard to good infection control practices.

The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with ample personal protective equipment including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available in the reception area for people to use and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the building.

We saw that there was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers

Good

Are services safe?

whilst awaiting collection from a registered waste disposal company. There were cleaning schedules in place and we saw there was a supply of approved cleaning products. Sharps containers were date labelled and not over-filled.

The practice had recognised that the decoration and internal fabric of the building was dated and not fully compliant with the latest guidance. For example the floors were not covered with a single sheet of material or coved up the walls. Taps were not elbow operated and sinks had overflows. The practice had successfully applied to NHS England for a grant towards the costs of upgrading the premises. We saw a timetable for the refurbishment to take place over the next few months.

Equipment

There was evidence of appropriate maintenance of the equipment including electrical checks and calibration of clinical apparatus such as blood pressure monitors and nebulisers. There were stickers on most equipment showing that portable appliance testing and proper calibration, where necessary, had been carried out. However some equipment had not been checked, this included some inhalers and a blood pressure machine. There was no document that set out all the equipment the practice had, how often it required checking or calibration and when this had been done. All equipment we saw appeared to be in good working order.

Staffing & Recruitment

Staff were recruited safely. The practice carried out the proper checks in relation to newly recruited staff. For one GP there was no criminal records check via the Disclosure and Barring Service (DBS) recorded. However, we were told this had been done and this GP was on a list of local GPs where evidence of a satisfactory DBS check is part of the application process. We looked at four staff files and they all had the necessary paperwork to show that references had been taken up and that gaps in employment had been accounted for. There were records to show that the professional registration checks for all relevant staff with the Nursing and Midwifery Council (NMC) or the General Medical Council (GMC) had been completed. The practice used regular locum GPs and only very occasional used GPs from an agency.

Monitoring Safety & Responding to Risk

We discussed with GPs an incident that had occurred within the practice. A patient had collapsed in a GPs consulting room and there was no pre-planned means of summoning assistance. The GP managed the patient's condition and the administrative staff provided help, they were able to do this as they were trained in basic life support procedures. The practice reviewed the event and put in place a new system using their internal computer network. There was a duty GP to respond to emergencies and urgent appointments. This GP also carried out most of the telephone appointments staff made. When staff made a telephone appointment they would colour code it so the GP could prioritise them.

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety.

There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception. The staff area in reception was kept secure preventing unauthorised access.

Arrangements to deal with emergencies and major incidents

All staff, save for one GP were shown on the practice's records as up to date with basic life support (BLS) training. This GP was on a list of local GPs where evidence of training in basic life support is part of the application process. There was a duty GP nominated to deal with emergency situations. The practice had a good supply of emergency medicines, which was in date, including oxygen. The emergency medicines were checked each month by a nominated practice nurse. We saw that there was a record of this.

Staff were aware of steps to take in the case of extreme events such as such as fire, inclement weather and loss of utilities. For example staff printed off a list of the following day's appointments in case the computer system failed so that the practice could continue to function. There were up to date business continuity plans to manage foreseeable events such as loss of the practice building. This document contained relevant contact details for staff to refer to in the event they required to report business continuity issues.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw several examples where care and treatment followed national best practice and guidelines. For example the emergency medicines and equipment held by the practice were consistent with the guidelines issued by the Resuscitation Council (UK). Patients' calls were screened by receptionists to ensure that they did not need immediate referral to a GP. Receptionists told us of the warning signs they used such as chest pains, dizziness or numbness. The decisions were based on experience and training they had received in the practice. However there was no record of the training that reception staff had had to carry this out. There was a guidance document, available on the computer system, for them to follow.

There was a range of clinics available to patients. This included chronic disease management – such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease (COPD). Other clinics covered maternity, contraception and family planning, smoking cessation and dietary advice. These were nurse led clinics. There was a nurse practitioner; (this is a registered nurse who has acquired the knowledge base, decision-making skills and clinical competencies for expanded practice beyond that of a registered nurse) and three practice nurses. They used National Institute for Health and Care Excellence (NICE) guidelines to support their practice. We saw that the guidance was followed in diabetic care with the nurse practitioner liaising with clinical nurse specialists from the local NHS trust where necessary. NICE guidance was followed when patients measured their blood pressure at home using the appropriate device, recording time and duration as recommended by the guidance.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. We saw examples of audits involving joint injection, orthopaedic referrals and dermatology referrals. These had identified areas for improvement which included laminated instruction cards in each consulting room, better publication of services, at the practice and in the surrounding area and several changes to specific patients' care and medicines.

There was an audit of inadequate samples of cervical smears. This showed that the practice was on target to achieve a decrease in the number of inadequate smears. The information for the audit was collected at the level of individual GPs and nurses so that the individuals could learn from any mistakes to improve their technique. These audits were repeated a regular intervals so that the improvements to individuals' learning could be monitored.

Effective staffing

We were told that some of the GPs had completed their revalidation and all were appraised annually. Some of the GP were appraisers, that is they appraised other GPs. However in some cases the paperwork was incomplete. Administrative staff were appraised annually and all had received their appraisal for the year. Staff we spoke with about the appraisal process said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to frankly examine their performance. Before the appraisal staff received a pre interview questionnaire. This allowed staff and managers time to consider their achievements for the past year and their aspirations for the next.

There was an overall training plan. We saw that mandatory training such as fire safety, manual handling and safeguarding had been completed for almost all staff so that the areas of training that were considered to be most important for the safety of patients and staff had been completed. Staff had protected learning time. There was a record of protected learning time and the staff could undertake training as group which allowed them to share learning experiences. However it was not clear what had been achieved as records did not clearly identify what learning had taken place.

Working with colleagues and other services

Patients' health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. There were multi-disciplinary team meetings (MDT). These were meetings that involved various professionals from outside and inside the practice for example, district nurses, social services, GPs and other specialists. The GPs worked with other health and social care professionals, to achieve a shared, integrated and personalised approach to the care of each patient. For example we saw that the practice followed up on blood test results which had not been

Good

Are services effective?

(for example, treatment is effective)

flagged up to practice correctly. Other examples included following up on scans and liaison with the clinical commissioning group about services which it deemed patients were not receiving quickly enough.

Two of the GP were GPs with special interests, one in dermatology and one in minor surgery including treating carpal tunnel syndrome. As well as treating their own patients they co-operated with other practices taking referrals for treatments such as basal cell carcinoma and carpal tunnel syndrome.

The practice worked in partnership with the local clinical commissioning group (CCG). With the support of the CCG there were community psychiatric nurses available to help ensure people who experienced poor mental health were supported.

Information Sharing

The practice had protocols and systems in place for referring patients to external services and professionals including acute and medical specialists, social services and community healthcare services. We saw evidence that the practice maintained links with community nursing teams, specialist mental health nurses, the long-term conditions nurse and the palliative care team. The palliative care meeting enabled GPs to discuss the needs of patients with chronic and terminal illness, they discussed arrangements for individual patients on advanced care plans and they ensured the out of hours service was informed of the care arrangements.

Consent to care and treatment

Staff we spoke with understood the consent and decision-making requirements of legislation and guidance, this included case law such as that in Fraser and Gillick. The records showed only one staff member who had received formal training in the Mental Capacity Act 2005 although staff, particularly GPs and nurses, were aware of the implications of the Act. Staff said that there had been no cause to hold any "best interest" meetings for patients who lacked the capacity to make decisions for themselves.

Health Promotion & Prevention

There was a range of leaflets available to inform patients on health care issues. These included smoking cessation, diet and healthy living. The practice website had a number of useful links and was easy to navigate. There was a page on long term conditions including mental health, cancer and asthma. There was a page on family health and this included links to "planning your pregnancy", child health and other family matters.

We looked at the child vaccination programme. Children in need of vaccinations were sent an appointment letter. The appointment date could be changed if necessary. In particular cases when a child did not attend for immunisation, despite a reminder letter, then this was shared with the local safeguarding board. This allowed the agencies concerned to share information so that concerns about vulnerable families could be shared to identify children who might be at risk.

We were told that all new patients were offered a health check. They were given a questionnaire and offered an appointment with the practice if necessary. This afforded new patients the opportunity to be assessed and to receive professional advice about their current health and lifestyle options.

There were leaflets referring patients to help from organisations such as MIND, SANE and the Mental Health Foundation. There was health promotion advice and information available at the practice. These facilities were also available through the practice's website.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. The reception area was busy and it was challenging to maintain patient confidentiality. However staff appeared aware of this and talked quietly so that it was difficult for them to be overheard. There was a private area where patients could talk to staff if they wished. There was a sign in the reception area to tell patients about this. We heard staff asking if patients would like to see a female or male member of staff and allocating appointments accordingly. All the patients we spoke with told us that they felt the staff at the practice treated them with respect and were polite. Patients said that staff considered their privacy and dignity and we saw notices informing patients that they could ask for a chaperone if they wished.

Consultation rooms had examination couches with surrounding privacy curtains and blinds at the windows. Staff told us that they used these when consultations or treatments were undertaken. We noted that during consultations the doors were closed and no conversations could be overheard. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms. The staff we spoke with demonstrated how they considered patients' privacy and dignity during consultations and treatments.

Care planning and involvement in decisions about care and treatment

Patients we spoke with said that they had been involved in the decisions about their care as much as they wished to be. They said that the GPs and nursing staff explained the care and treatment that was being provided. Patients received appropriate information and support regarding their care or treatment. There was a range of leaflets available in the reception area. These provided general health promotion and also specific advice about common conditions.

The surgery website provided details of languages other than English that were routinely available. There was no routine access to translation services, such as telephone language lines. The practice said this had not been a problem but that were aware of these services and would use them if it was necessary.

There was information about appointments, clinics and services on the practice website. The website also provided links to many other useful sources of information including cancers, cancer support, mental health, AIDS, epilepsy and other health promotion advice. There was a minor operations suite at the practice and we spoke to the GP whose speciality this was. We saw that there were separate protocols and consents for minor operations. There were information leaflets relating to different procedures, there were leaflets explaining possible complications and how to deal with them.

We saw from the NHS choices website several patients had commented about their care. The comments were all positive.

Patient/carer support to cope emotionally with care and treatment

Staff we spoke with showed an understanding of the impact that a patient's care and treatment might have on their physical and emotional wellbeing. We saw staff talking with patients taking this into account, For example staff understood how the condition of patient's spouse, who was severely ill with a chest condition, impacted on that person's ability to attend the practice and get repeat prescriptions.

The practice actively worked to identify patients who were acting as carers for other people, whether those people were registered with the practice or not. We saw that the practice used their computerised notes system to "flag" individuals who were carers so that they could take this into account when making appointments or providing care. The practice website had an appeal to carers with a link so that anyone could notify the practice that they were a carer. There were further links to different websites providing help for carers.

The GPs worked closely with the local hospice which had a hospice at home service. There was shared responsibility with GPs, the hospice and nurse specialists. In addition the practice held three monthly palliative care meetings when such patients and their care were discussed with others such as the hospice, district nursing services and social services where appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We heard staff making appointments. They were pleasant and respectful to the patients. They tried to accommodate the times that the patients asked for. When they were not able to do this they talked with the patients to identify other suitable times. We heard reception staff offering patients the choice about being seen by a male or female member of staff. Staff helped patients who had mobility problems.

The practice was developing 'named doctors for all patients over 75 years of age'. These were allocated by identifying their usual GP but this work was, as yet, incomplete. After an audit into a particular treatment identified delays, the practice took ownership of the problem and the practice now treated patients' dermatology problems and carpal tunnel syndrome. They also took similar referrals from other practices.

The practice had the services of a community psychiatric nurse (CPN) to help with this and the local clinical commissioning group had allocated two more CPNs to assist in developing the service.

Tackling inequity and promoting equality

Patients with disabilities could access the practice. There was a ramp leading to the front door so that patients in wheel chairs could use it.

All patients who had a diagnosis of dementia were flagged on the practice's computer system. When someone accessed these records a message came up on the screen informing the person of the diagnosis. This ensured that all staff were informed and aware so that they could provide the relevant support to patients. There was a register of patients with a diagnosis of dementia and the practice nurse reviewed the care and treatment of these patients with their carer, when there was a carer available. Although they had a register in place, the practice had not been able to achieve a similar level of service for patients with learning disability due to difficulties liaising with the local social services.

Access to the service

The practice aimed to see patients within 48 hours when requested and in the main they achieved this. There was a nurse specialist who had urgent appointments available each day. The nurse treated patients and only referred on to GPs where necessary. There was also a "duty GP system" for those who needed urgent access. The GP telephoned the patient to assess the patient's needs. A number of emergency slots, for appointments with GPs, were reserved for 'on the day' use only.

Patients were asked to book longer appointments, that is double appointments, if they thought their visit to the GP would take more than 10 minutes. The receptionists were aware of and were able to manage this. Late evening and early morning "commuter" surgeries were available by appointment in the evenings on Monday's and Thursday's and in the early morning on Wednesday's.

Patients we spoke with all expressed confidence that urgent problems or medical emergencies would be dealt with promptly and staff would know how to prioritise appointments for them. One patient described how they had tried to get a same day appointment. The receptionist said that all these appointments were taken. The patient explained that they had been seen by a nurse at their workplace who had advised that they should see a doctor. When the receptionist heard this she extended one of the urgent sessions so that the patient could be seen that day.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. There was a register of complaints. We saw that there had been learning from complaints. For example one patient complained about the time that a hospital referral was taking. As a result the practice had trained staff in the use of "Choose and Book" a national system that allows patients to choose from a wider range of providers, to assist patients. Another case concerned an incorrect prescription where two medicines, both of which the patient was taking, had very similar names. The practice took advice from the local medicines team and was able to change one prescription to the generic equivalent which had a very different name. This greatly reduced the risk of the event happening again.

We were told that complaints were formally discussed amongst staff so that lessons learned could be shared. However there were no minutes of these meetings so the practice could not show that all staff had received the information to ensure they had learned as a result of any complaints relevant to their area of work.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had acted on the results of its patient survey. The practice had an action plan to deal with the issues the survey had highlighted. Actions taken so far had included; a new automatic check in machine, improvements to the decoration of the waiting area and extending the use of text messaging to remind patients of their appointment times.

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

We spoke with management at the practice, who told us that they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams. Staff consistently said that they understood what the practice stood for, for example trying to ensure that patients saw their own (preferred) doctor whenever possible and trying to respond to patients' needs to the best of their ability at all times.

Governance Arrangements

The practice carried out audits. There had been audits of the medicines' reviews carried out by GPs. This had been adjusted to allow for the hours worked by different GPs so had given the practice a balanced view of the comparative work rate of GPs. There had been prescribing audits, reviews of complaints and infection control audits all of which had led to changes in practice to improve patient care.

There were some mechanisms to manage governance of the practice. The practice had recently lost one partner and was operating with only two partners as a result clinical governance meeting had become less frequent. However the practice had restarted clinical governance meetings in June 2014. These were scheduled weekly with some interruptions during the summer months. These meetings discussed issues such as the unplanned admission of patients to hospital, infection control, the use of audits to improve care and the patients' experience of care and safeguarding. One meeting focussed on significant events and the actions that arose from them. From later meetings we saw that the actions that had been raised had been addressed.

There were regular practice meetings, these covered a wide range of subjects and appeared very positive. However, there were no clear minutes to reflect discussions or notes of what actions needed to be carried forward or who would be responsible for completing them. For example there were requests for new equipment or the drafting of a new protocol. During the inspection we saw that some of the issues had been addressed. For others it was not possible to see whether the request had been met or the task completed. We could see that the practice had identified issues that needed action but could not always say whether the action had been carried out. The practice had recognised that the quality of data recording and its management could be improved and had recruited an experienced practice manager, part time, to help the existing practice manager to implement robust systems to address this.

Leadership, openness and transparency

The GPs we spoke with felt that staff were willing to speak out regarding concerns and comments about the practice. Staff told us that the GP and practice manager were very approachable. Receptionists we spoke with said that they would interrupt a consultation if they had an urgent concern. The leading partner told us that this was the message that staff had been given and told us of occasions when this had happened. The practice was applying to become a training practice and therefore had recently been subject to an external review. They had undergone an inspection by the local training authority for GPs (the deanery). The deanery had reviewed the practice's processes and outcomes had authorised the practice to take on year two training for GPs, this was the first step to becoming a training practice.

Practice seeks and acts on feedback from users, public and staff

The practice had systems in place to seek and act upon feedback from patients. There was a patient participation group (PPG) and although the practice had found it hard to maintain interest in the group, there been 12 attendees at a recent meeting. The concerns raised were acted on by the practice when practicable. For example the PPG had raised concerns about a long wait for appointments and the practice had recruited two GPs to ease the situation. Issues raised by the PPG members and by patients' survey were included in the practice's action plan for the year. These included allocating one receptionist specifically to help patients check in and promoting more use of on-line services.

Management lead through learning & improvement

Staff we spoke with said that they were supported to develop their skills. We saw that GPs and nurses staff were supported by other GPs and nurses to improve their skills such as in the administration of vaccines. Administrative staff also talked of the training that they received which included managing complaints, investigations and employment law.

Are services well-led?

Good

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

The practice had protected learning time (PLT) when the practice was closed to the public to enable staff to meet and discuss issues and to train. Staff we spoke with felt these sessions were very useful in updating and seeking the views of staff. There was information as to what was on the agenda for discussion but no notes or actions from the day. For example in June “confidentiality – ideas for the reception” was tabled to be discussed.

The prevalence of patients with mental health problems, that is those diagnosed with a mental health problem, had, historically, been lower in the practice than locally and nationally. The practice had recognised this and had, over the last few years, worked hard to identify patients with mental health problems and to ensure that their diagnoses were properly recorded so that there was accurate information that reflected the work done by the practice. As a result the practice’s results for diagnosis of patients with mental health problems were now more closely aligned to that expected locally.