Springhill 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 Springhill Medical Centre on 10 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- The practice was clean and hygienic and had arrangements for reducing the risks from healthcare associated infections.
- Patients' needs were assessed and the practice planned and delivered care following best practice guidance.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had introduced ways to assist patients with the highest level of need to receive care quickly and easily.
- The practice had a well-established and well trained team with expertise and experience in a range of health conditions.
- Patients said that staff were compassionate, supportive, friendly and understanding.
- Information about services and how to complain was available and easy to understand. The practice responded to complaints in a positive way.
- The practice communicated with patients and acted on feedback to improve the service they provided.
- The practice had recognised that internal communication processes was an area which they needed to develop and improve.

We saw the following area of outstanding practice

Summary of findings

- The practice had introduced a system that they had called 'Purple patients' to assist patients with cancer, autism, significant incapacity and those using oxygen to obtain prompt appointments. The scheme was introduced to take into account of the particular needs of those patients. This included the specific risk of infection for cancer patients during periods of receiving chemotherapy. The scheme involved patients being flagged on the practice computer system as 'purple patients'. The practice had made a commitment that these patients could expect continuity of care by seeing the same GP for their appointments. The practice also provided same day appointments for them and as far as possible accommodated their preferred time. 'Purple patients' or their carers could also be offered a side room to wait in until their GP called them if their circumstances made this necessary.

There were also areas where the practice needs to make improvements

The practice should –

- Review its recruitment policy and procedures to make sure these include all necessary employment checks for all staff.
- Review opportunities for the practice team to share information about the practice's vision and strategy and to share learning from significant events and complaints.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice investigated significant events thoroughly and had an open approach to learning and improving when anything went wrong. Information about safety was valued although arrangements for sharing information within the practice team needed to be developed. The practice assessed risks to patients and had systems for managing specific risks such as fire safety, infection control and medical emergencies. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Patients' received care and treatment which took account of National Institute for Health and Care Excellence (NICE) and local guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice encouraged their continued learning and development.

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 that staff were compassionate, supportive, friendly and understanding. National data showed that the practice scored well for treating patients with care and concern and involving them 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 outstanding for providing responsive services. The practice was aware of the needs of their local population and recognised the importance of developing their services to meet current and future demand. The practice had taken steps to improve access to the service in response to patient feedback; this included extended hours on some days each week. Urgent appointments were available the same day. The practice had introduced ways to assist patients with the highest level of need to receive care quickly and easily and where necessary wait for their

Summary of findings

appointments away from the main waiting room. For example, cancer patients with compromised immune systems due to chemotherapy had this option. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system and the practice responded quickly to issues raised although arrangements for sharing learning from complaints needed to be improved.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a vision and strategy for the future which took the future needs of the population into account although this had not been proactively shared with the wider practice team. There were weekly partner meetings and a range of separate meetings for staff fulfilling other roles rather than for the whole staff team. Because of this the practice did not have a cohesive way for the whole team to learn and develop together. The practice had a number of policies and procedures to govern activity and these were available for all staff to access on the practice computer system. The practice had an active patient participation group (PPG) and had worked closely with them to make improvements to the service.

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

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice offered proactive, personalised care to meet the needs of the older people in its population. Older patients were assessed to ensure they received the care they might need in respect of frailty or dementia. The practice had systems to alert staff to patients with significant health and care needs and those at the end of life. These included arrangements to enable patients to get through to the practice easily by telephone and be seen promptly by a GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. The practice had systems to respond to the needs of patients with significant health problems which could be life threatening or lead to hospital admission and those at the end of life. These included a designated telephone line to enable patients to get through to the practice easily and continuity of care with a named GP. In certain circumstances the practice arranged separate waiting facilities for these patients.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held a weekly baby clinic, and provided individual appointments for childhood vaccinations. Immunisation rates were relatively high for all standard childhood immunisations. One of the GPs had a special interest in women's health and provided a family planning service including fitting long acting contraceptive devices. The GPs and practice nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances. Appointments were available outside of school hours.

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Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The practice provided extended opening hours for people unable to visit the practice during the day. These were available one morning and two evenings each week. Patients could book appointments online and there were arrangements for patients to have telephone consultations with a GP where this was suitable. Students and other young people were offered Meningitis C vaccinations. Electrocardiograms (ECG) were provided. An ECG can help find the cause of symptoms such as palpitations or chest pain. The practice hosted clinics run by staff from a local hospital to screen for abdominal aortic aneurysm, a dangerous swelling (aneurysm) of the main blood vessel that runs from the heart to the rest of the body. Patients were therefore able to have these checks carried out at their local practice rather than needing to wait for hospital outpatient appointments. One of the GPs had a special interest in women's health and provided endometrial biopsy, a procedure used to diagnose specific conditions linked to painful and heavy periods which would normally be carried out in a hospital. Patients at the practice were therefore receiving this service locally and without needing to be referred to a hospital and wait for an appointment.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a learning disability (LD) register and patients with learning disabilities were invited to attend for an annual health check. Staff told us that the practice did not have any homeless people or traveller families currently registered at the practice. Staff at the practice worked with other professionals to help ensure people living in difficult circumstances had opportunities to receive the care, support and treatment they needed. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held a register of people experiencing poor mental health and invited them to attend for an annual health check. The practice referred patients to NHS psychology services through the Improving Access to Psychological Therapy (IAPT) team which provided

Summary of findings

counselling services there three days a week. The practice was alert to the complex needs of people who were living with dementia and provided screening for dementia and referrals to the NHS memory clinic data.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at eight Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with two patients one of whom was a member of the Springhill Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. Data available from Public Health England and the NHS England GP patient survey showed that the patients had reported positive views about the practice. Patients had scored the practice slightly higher than average for overall experience and for their GP or nurse involving them in decisions about their care and treatment and treating them with care and concern.

Although eight comment cards was a small sample of the practice population, the information written by patients in these reflected the national data and presented a positive picture of patients' experiences at Springhill Medical Centre. The two patients we spoke with were also positive. Patients described being listened to attentively by their GP and receiving prompt care and attention when this was needed, including in an emergency situation in one case. Patients also wrote that their GP had taken great care to make sure they understood their treatment and the options available to them. Patients' comments included words such as compassionate, caring, supportive, friendly, obliging and understanding.

We looked at the results of a survey carried out by the PPG during 2013/14. This showed that the majority of patients were pleased with most aspects of the service they received. During the inspection we learned that some areas which had lower scores had already been improved by the practice or this was work in progress. We also saw the results of a local neighbourhood plan survey about health services in May 2014. This gave a positive picture overall recognising the medical centre as an important and valued community asset but reflecting some concerns about access to appointments and the growth of the local population. The practice was aware of these issues and had worked with the PPG to make improvements.

None of the eight cards we received contained any negative comments or concerns.

Areas for improvement

Action the service SHOULD take to improve

- Review its recruitment policy and procedures to make sure these include all necessary employment checks for all staff.
- Review opportunities for the practice team to share information about the practice's vision and strategy and to share learning from significant events and complaints.

Outstanding practice

We saw the following area of outstanding practice

- The practice had introduced to assist patients with cancer, autism, significant incapacity and those using oxygen to obtain prompt appointments. The scheme was introduced to take into account of the particular needs of those patients. This included the specific risk of infection for cancer patients during periods of receiving chemotherapy. The scheme involved patients being flagged on the practice computer system as 'purple patients'. The practice had made a commitment that these patients could expect continuity of care by seeing the same GP for their appointments. The practice also provided same day appointments for them and as far as possible accommodated their preferred time. 'Purple patients' or their carers could also be offered a side room to wait in until their GP called them if their circumstances made this necessary.

Springhill 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, a practice manager and a second CQC inspector.

Background to Springhill Medical Centre

Spring Hill Medical Centre is a semi-rural practice, covering Fillongley, Arley, Galley Common and all of the Nuneaton area. It has around 10,000 patients but significant numbers of new homes are planned bringing the probability of increased patient numbers within a few years. The practice is in a spacious purpose built building with a large free car park with disabled spaces nearest to the entrance. The practice population has a slightly higher proportion of people aged between 40 and 50 and children under ten than the national average. The practice has lower than average numbers of patients over 65 years of age.

Springhill Medical Centre has a branch surgery called Galley Common which is about ten minutes' drive from the main practice. We did not visit the branch surgery as part of this inspection. This was because we did not identify any concerns about the branch during our planning or while inspecting Springhill Medical Centre.

The practice has three partners and two salaried GPs. Three of the GPs are male and two are female. The practice has three practice nurses and a locum health care assistant who works at the practice regularly.

The clinical team are supported by a practice manager, a deputy practice manager, a patient administrator and prescribing manager, IT team leader and a team of reception staff and medical secretaries. The practice also employs their own maintenance and housekeeping team.

Springhill Medical Centre is a training practice providing up to two GP training places for GP registrars. A GP registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

Data we reviewed showed that the practice was achieving results that were in line with national or Clinical Commissioning Group averages in most areas of clinical practice and patient satisfaction.

The practice does not provide out of hours services to their own patients. Patients are provided with a telephone number to obtain details of the local out of hours GP arrangements provided by Care UK who are based at the George Eliot hospital site.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our

Detailed findings

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.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Warwickshire North Clinical Commissioning Group (CCG), NHS England Area Team and Warwickshire Healthwatch. We carried out an announced visit to Springhill Medical Centre on 10 February 2015 but did not visit the branch surgery at Galley Common. We sent CQC comment cards to the practice. We received eight completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with a total of 10 staff including the practice manager, GPs, a GP registrar, practice nurses and members of the reception and administrative teams. We also spoke with two patients one of whom was a member of the practice's Patient Participation Group (PPG).

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

The practice used a range of information to identify risks and improve patient safety. This included significant events, national patient safety alerts and comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a GP described a significant event involving an unexpected diagnosis. This had led the practice to examine how the patient's care had been managed so that if a similar situation occurred the diagnosis would be considered earlier.

The practice had been recording significant event information since 2002 showing a long standing recognition that monitoring safety was important.

Learning and improvement from safety incidents

The GPs, practice nurses and practice manager received national patient safety alerts and these were saved on the practice computer system where all members of the team could access them.

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. The system included a suitable reporting form that all staff had access to. The forms we saw had been completed thoroughly by staff and followed up by the practice manager.

GPs we spoke with gave us examples of changes to practice which had been acted on in a timely way. A GP told us about a situation where a patient had become unwell during a procedure. The GP was working alone and found it difficult to alert staff that they needed assistance. As a result the practice installed a call bell in the relevant treatment room. They also introduced a policy that a second member of staff must be readily available whenever minor surgery or certain other procedures were taking place.

We found that staff reported significant events and the practice investigated these. We received mixed accounts of how often significant events were discussed when we asked staff. We confirmed with the practice manager that they and the GPs held weekly meetings so any actions needed were addressed promptly. Annual meetings were held to review significant events over the year and the learning and actions from these. We looked at the minutes of a significant event meeting in August 2014. We noted that the events discussed dated back to March 2013. The meeting was attended by three GPs and the practice manager. Each incident discussed had action points noted but the record did not include dates to confirm that each was dealt with in a timely way.

We also saw follow up notes describing individual significant events. These showed an open assessment of failures in the practice's processes by the team. However, the notes did not specify clear timescales and responsibility for the improvements needed to enable the practice to use these to monitor and audit improvements.

The non-clinical staff told us that they did not take part in meetings to talk about significant events or complaints unless they were directly involved in the issue being discussed. Because meetings to discuss significant events did not include the whole staff team the practice did not have a structured way for the whole team to learn from significant events together.

Reliable safety systems and processes including safeguarding

The practice had a lead GP for safeguarding vulnerable adults and children. The staff we asked knew who this was and who to speak with if they had a safeguarding concern. Staff understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. Members of the team knew how to access information about safeguarding on the practice's computer system. A GP gave us an example of a concern they had identified and how they had acted on this by referring the case to the local safeguarding team.

The lead GP and other clinical staff had regular contact with local health visitor teams about child protection concerns. One of the teams did this through daily telephone calls and the other came to the practice each week. They took part in an annual meeting to review how communication and liaison was working. The practice manager told us they also contacted the health visitor teams every two months to maintain open communication.

The practice had safeguarding policies and procedures for children and young people and for adults. These were based on national guidance and had been tailored to the needs of the practice. We noted that the policies referred to

the Independent Safeguarding Authority (ISA). The ISA was replaced in 2012 when it joined with the Criminal Records Bureau to form the Disclosure and Barring Service. Whilst it needed to be updated the policy provided guidance for staff about identifying and reporting abuse and neglect. The policy included information about important contact numbers for the multi-disciplinary child and vulnerable adult safeguarding teams and decision making flow charts to assist staff. The local multi agency safeguarding forms were available in the practice for staff to use when needed. The practice had clear systems, including alerts on the practice computer system which made sure that relevant staff were aware of any child known to be at risk or who was in the care of the local authority. There was information about safeguarding contacts and arrangements on the noticeboards in treatment rooms.

We saw evidence that staff regularly completed safeguarding training for children and vulnerable adults at a suitable level according to their role at the practice.

The practice had a chaperoning policy based on national and local guidance. The policy highlighted cultural considerations, confidentiality, and consent. In house training was provided for staff who fulfilled this role. Signs were displayed within the practice to inform patients that chaperones were available and there was a checklist for staff within the policy as a reminder of the arrangements. Training records showed that three staff had completed this training and that five more were scheduled to do so during 2015.

The practice had a whistleblowing policy which included information about the rights and responsibilities of staff. The document included information about whistleblowing legislation and guidance from the General Medical Council (GMC). The document also provided contact details for Public Concern at Work, an independent organisation which provides guidance and support to whistleblowers.

Medicines management

We saw that the practice had policies and procedures relevant to the safe management of medicines and prescribing practice. A member of the practice support team was responsible for monitoring prescribing at the practice in respect of national and local prescribing guidance. They told us that they worked closely with the Coventry and Warwickshire Area Prescribing Committee and local pharmacy support team. They used these as sources of information to inform and alert the GPs to NHS preferred medicines. In situations where it was found that an alternative medicine would meet patients' needs effectively they carried out a computer search to compile a list of patients. If a GP decided that a patient's medicine should be changed they wrote to them to explain this. The practice used a computer based system to help them manage 'shared care' prescribing arrangements where specialists were involved in the care of patients registered at the practice.

Patients could order their repeat prescriptions in person, online or by telephone. There was a process for prompting patients who needed to have their medicines reviewed by a GP and this was done at suitable intervals depending on the specific requirements relating to individual medicines.

We looked at the arrangements for the security of blank prescriptions. The practice stored prescription pads securely and had recently introduced a recording system in accordance with national guidelines for the safe storage, recording and use of prescriptions. We noted that they had not recorded details of prescription pads already held by the GPs. The practice confirmed that they did this straight after the inspection.

The practice nurses were responsible for maintaining vaccine stocks. We saw that the practice had arrangements for the receipt, storage and recording of all vaccines coming into the practice. A practice nurse showed us their records of the numbers of each type of vaccine that the practice had in stock and the expiry dates. We noted that the form did not include a space to record the batch numbers of the vaccines and the nurse said they would add this to make the record more comprehensive. The practice manager subsequently confirmed that this had been done. The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance and had copies of these available to refer to. We saw evidence that staff monitored and recorded the temperatures of the fridges where vaccines and other temperature sensitive medicines were stored.

Cleanliness and infection control

The practice was visibly clean and hand washing facilities and hand gel were available for staff and patients.

One of the practice nurses was the lead for infection prevention and control (IPC) and had completed relevant training to support them in this role. They told us that the

practice approach was that the whole team were responsible for high standards of hygiene and cleanliness. They had carried out six monthly IPC audits using a recognised NHS format. There was an action plan done for each audit so that any improvements needed were acted on.

The practice manager was the lead for legionella precautions. Legionella is a bacterium that can contaminate water systems in buildings. The practice had a legionella risk assessment which identified the premises as low risk because there were no hot or cold water storage tanks. A shower in the building was identified as a potential risk because it was used infrequently. The practice's cleaning schedule included running water through the shower every month as a precautionary measure.

The staff training records showed that staff completed annual training refreshers in infection prevention and control.

General cleaning of the premises was done by cleaners employed by the practice. They were managed by the practice manager. The cleaning staff kept records using cleaning schedules to help the practice manager monitor the standards of cleanliness. Cleaning equipment and products were kept securely and information about safe use of cleaning materials was readily available. Staff told us that clinical equipment was cleaned by the practice nurses who were responsible for making sure equipment in the treatment rooms was clean.

The practice had a plentiful supply of personal protective equipment, such as disposable gloves and aprons, for staff to use. We saw that suitable foot operated bins were provided for general and clinical waste. There were disposable privacy curtains in treatment rooms and staff had recorded the date these had been changed on the labels provided for this. The practice showed us that following an IPC audit they had installed a hatch with a lockable door in the patients' toilet. This was used by patients to pass urine samples to staff without having to carry these through the practice. The practice felt that not only was this more hygienic but that it was also more dignified for patients.

There was a sharps injury policy and procedure so staff had information about the action to take if they accidentally injured themselves with a needle or other sharp medical device. Information for staff was displayed on noticeboards in the treatment rooms. The practice had comprehensive written confirmation that all staff were protected against Hepatitis B and expected all new staff to have this checked when they started work at the practice.

The practice had contracts with a specialist contractor, relevant local authorities and with George Eliot Hospital for the collection for the collection of non-clinical and clinical waste. They had suitable locked storage for all waste that was waiting for collection.

Equipment

In our discussions with staff we established that the practice had the equipment they needed for the care and treatment they provided. We saw evidence that equipment was maintained and re-calibrated as required. This work was carried out by a specialist company and we saw that this was last done on 23 January 2015. Portable electrical equipment was tested every year.

A specialist fire safety company completed a fire risk assessment of the building before it opened in 2012 and had returned to update this annually. The practice had fire safety records confirming that they completed weekly fire alarm tests and regular checks of fire safety equipment.

Staffing & Recruitment

The practice had a recruitment and criminal records check policy. These did not contain specific details of the policy and procedure at the practice for carrying out checks through the Disclosure and Barring Service (DBS) and which members of the team they would obtain these for. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable.

We looked at two staff files; one for a member of the clinical team and one for a member of the non-clinical staff. The practice had been provided with a previous criminal record check by a member of non-clinical staff who would not have unsupervised access to patients. They had not carried out a risk assessment setting out how they decided an up to date criminal record check was not necessary. The recruitment policy did not describe how the practice satisfied itself of the conduct of job applicants in previous employment involving the care of children or vulnerable adults. We noted that the practice had obtained references for one of the two staff but not the other.

Good

Are services safe?

We met a GP registrar who had recently started at the practice. A GP registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. They confirmed that they were supported by the practice team and had had a well organised and structured induction period which they had not yet completed. Whilst they had been at the practice only a short time they were able to tell us with confidence about the practice's arrangements for safeguarding, prescribing and medicines reviews, complaints, chaperoning and various other key topics. They also told us that the practice had arranged for them to go out with local health visitors which they had found a valuable experience.

The numbers of patients registered with the practice meant that each GP was very busy and saw a high number of patients each day. However, 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.

Monitoring Safety & Responding to Risk

The practice had a health and safety risk assessment and a comprehensive risk register. We saw from the training records that staff received training in respect of health and safety.

The practice had arrangements for identifying those patients who may be at risk. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable. Reception staff also had this information to help them prioritise potentially urgent cases.

The practice employed a maintenance team and we saw that the premises were well maintained.

The practice had a zero tolerance approach to abusive or aggressive behaviour from patients towards other patients or staff. Information about this was included in the patient leaflet and displayed in the practice.

Arrangements to deal with emergencies and major incidents

Staff at the practice completed annual cardiopulmonary resuscitation (CPR) training and five staff had also completed first aid training. The practice manager had a system for monitoring when refresher training was due. Staff told us there was an emergency call system on every computer in the practice that staff could activate. This alerted all staff to any emergency in the building and also identified which room this was in.

The practice had oxygen, an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm) and emergency medicines available for use in a medical emergency. We saw that staff checked these regularly to make sure they were available and ready for use when needed. We noted that the emergency equipment and medicines were kept on a trolley in a corridor so they were readily available when needed. We questioned whether this might be too accessible to patients walking through the building and the practice said they would review this. The GPs had their own bags for visits to patients at home. One of the practice team checked these every month to make sure they contained the necessary equipment and medicines and that everything was in date and suitable to use. They kept written records of these checks.

The practice had two fire safety wardens and staff had annual fire safety updates.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff with copies in reception, the manager's office and at the branch surgery. All of the GP partners and management team had copies at home so that it was available all of the time. The areas covered included problems such as computer failure, loss of power, heating or water, adverse weather, incapacity of GPs or other staff and security breaches. The document contained relevant contact details for staff to refer to and included risk assessments and management plans for the topics covered.

The practice also had a risk log which included general health and safety and other risk assessments and control measures for a variety of short, medium and long term risks which might occur in a busy GP practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurses we spoke with were familiar with current best practice guidance, and referred to guidelines from the National Institute for Health and Care Excellence (NICE) and from local sources such as NHS England. We saw that the team had access to these through the practice's computer system and team members told us about this. One of the partners specialised in women's health and had access to national guidelines for topics such as contraception which they shared with other members of the team.

The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. Data available to us showed that the practice had achieved results for QOF which were generally in line with national averages. We saw that the practice had achieved lower than the national average results in two areas related to the treatment of diabetes. During the inspection the GPs were able to show us that they had addressed these areas fully.

Overall the practice was aware that some of their QOF results during the previous year had been lower than they would have liked. This was partly due to a short term staff shortage and they believed that they were now on track to achieve improved results for the current year.

Several patients described situations where GPs at the practice had assessed their health needs and referred them for the treatment they needed.

Management, monitoring and improving outcomes for people

The practice was working towards having care plans in place for all patients with chronic obstructive airways disorder, asthma, mental health needs and those receiving care at the end of life. During the inspection we spoke with a patient who told us that they had relatives with long term conditions and confirmed that the practice monitored their health closely. The practice confirmed that they provided annual health checks for patients with asthma, COPD and diabetes. They also hosted retinopathy clinics run by staff from a hospital in nearby Rugby to monitor the eyesight of diabetic patients.

The GPs, practice nurses and other members of the practice team worked together to monitor and improve outcomes for patients. For example, one member of the support team was responsible for checking and following up when patients with long term conditions were due for their routine health checks. They showed us their system and explained that they sent up to three reminder letters to patients who did not attend for their health checks. Reminders about recalls for health and medicines reviews were also printed on patients' prescriptions. Another member of the support team monitored prescribing at the practice and made sure that the GPs were aware of any national initiatives regarding medicines. The GPs and practice nurses provided a range of specialist skills, knowledge and interests and provided or hosted a variety of services to patients which avoided referrals for hospital treatment in some circumstances. If patients with long term conditions were too unwell to attend the practice for their routine checks a GP or practice nurse visited them at home.

The practice was working to avoid unplanned hospital admissions for patients with long term conditions and was taking part in an NHS England unplanned admissions enhanced service. The practice provided us with information showing that they had exceeded the 2% target for the number of patients on their unplanned admissions register who had a care plan. Their target number of patients was 154 and the practice had care plans in place for 185 patients.

As part of the unplanned admissions enhanced service the practice gave patients with complex care needs a designated ex-directory telephone number. This was for them to use if their condition deteriorated so they could get through on the telephone quickly. Patients calling this number were spoken with by a GP straight away so they could complete an initial telephone assessment with the patient or relative (with consent). Staff told us that many patients with long term conditions also had specific 'rescue' medicines prescribed for them to keep at home for use when needed. For example, patients with lung conditions might have antibiotics and anti-inflammatory medicines available so that they could start treatment rapidly if they developed an infection. The ex-directory number was also provided to the care home where some patients lived and to other key professionals such as the community mental health team.

Good

Are services effective?

(for example, treatment is effective)

When patients on the practice's unplanned admissions register had been admitted and then discharged from hospital the practice telephoned them to follow up their care needs.

One of the female GPs had a particular interest in women's health and carried out a procedure called endometrial biopsy. This was used to diagnose specific conditions linked to painful and heavy periods and would normally be carried out in a hospital. Patients at the practice could therefore have this procedure locally and without needing to be referred to a hospital and wait for an appointment. This GP also talked to us about audits they had done in respect of cervical smear tests and long lasting contraception methods.

One of the GPs showed us their first cycle of a clinical audit looking at patients on a specific medicine prescribed for diabetes. This had involved identifying patients taking this medicine and reviewing whether or not this was working well in their individual case. Where patients were not benefitting they had been changed to another medicine. The GP had repeated the audit after nine months to continue to monitor the ongoing treatment of patients whose medicines had been changed and those where no change had been made.

One of the salaried GPs spoke with us about a clinical audit they had carried out in respect of patients with gout, a condition which causes attacks of pain and swelling in one or more joints. The audit took into account national guidance regarding the management of gout, particularly for patients with other long term conditions. As a result of this audit the practice wrote to all patients who had been diagnosed with this condition to ask them to attend for blood tests and have their medicines and overall health reviewed. The GP who carried out the audit planned to share the outcomes with other GPs at the practice and to repeat the audit. We saw that the practice carried out audits of their minor surgery procedures. The results of these showed that in 2013/14 two out of 237 who had minor surgery patients had developed an infection after their procedure. The audit for 2014/15 showed that none of the 218 patients who had procedures developed an infection.

The practice took part in a virtual ward scheme aimed at reducing hospital admissions and discharge delays. Virtual wards enable healthcare professionals to provide medical care and monitoring to patients in their own homes rather than in a hospital setting. The practice used the gold standards framework for end of life care. They had a register of patients who needed care and support though this stage of their lives and took part in quarterly meetings with other professionals involved in their care.

A GP told us that the practice encouraged patients with complex needs to book appointments with the same GP so that continuity of care was easier to achieve. All patients over 75 had a named GP for the same reason and in line with best practice. The practice was using a specific screening tool for older people to assess their frailty. They were also screening for dementia in appropriate circumstances. Older patients taking more than five medicines a day were signposted by the practice to the nearby pharmacy for help to manage their medicines effectively by using a blister pack system. These systems package medicines according to the day and time of day that each one should be taken and can assist patients to take their medicines at the right time.

Effective staffing

The GPs and nurses at the practice had a wide range of knowledge and skills. Their knowledge and skills were updated with ongoing accredited training and in-house training. The nurses gave us examples of training they had completed or planned to do. One was starting a diploma course for chronic obstructive airways disease (COPD) and had already completed a specialist course for spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function). One of the GPs with a special interest in women's health told us they provided in house training for the GPs and practice nurses in respect of family planning and contraception.

The GPs told us that their annual external appraisals and requirements for revalidation were up to date. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.

The practice manager had a system for recording and monitoring training for the staff team. This showed that staff were up to date with attending mandatory courses such as annual basic life support. We noted that some individual induction training records did not provide clear

Good

Are services effective?

(for example, treatment is effective)

information about the progress of new staff through the induction process. The practice manager explained that they were developing a new induction procedure which would make sure this information was recorded in future.

The practice showed us their plan for ensuring all staff received a performance appraisal with dates set for these to be completed for all non-clinical staff by the end of February 2015. The practice manager explained that they had completed few appraisals during 2014 due to being away for part of that year. We saw an example of a completed staff appraisal form. This used a comprehensive format and was well completed.

Members of the practice team had regular protected learning time to enable them to take part training and shared learning to contribute to their continuous professional development (CPD). The practice manager had completed a diploma level course in management and was working towards a degree in business studies to enable them to develop their knowledge and skills.

A GP registrar had joined the practice a week before our inspection. They gave us a positive view of their first few days and the support they had received to help them settle in and start to develop the knowledge and experience needed to be a GP. They described a well organised initial induction process which had included several essential learning topics within the first few days including health and safety, fire safety, child and adult safeguarding. They had begun to spend time with the GPs at the practice and had been given clear information about the arrangements for becoming increasingly involved in patients' consultations.

Working with colleagues and other services

We met a member of the team who was responsible for typing and sending letters about patients that GPs were referring to specialists. They described working closely with the GPs who dictated letters onto audio tape and informed them if any were urgent. They had a system that they told us worked well which meant letters were dealt with in order of priority or, if not urgent, in date order. They told us that urgent letters went out within 24 hours and that they aimed to send all letters within one week. We observed that the tapes waiting to be dealt with were less than a week old.

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff told us that results were directed to the GP who requested the tests and they were responsible for the action required. If they were not at work the other GPs reviewed the information so that there were no avoidable delays for patients. The practice had written guidance for staff describing how this process worked. This included information about how work should be allocated between GPs and monitored to ensure it was dealt with.

The practice took part in multidisciplinary team meetings to discuss the needs of complex patients. For example they met every three months with palliative care nurses to discuss patients with end of life care needs. They also met with health visitors and social workers to discuss children on the at risk register. They were involved in a range of other meetings with other health and care providers including local commissioners.

The practice was aware that they had higher numbers of referrals to secondary care than the national average. They told us that they were confident that all the referrals they made were appropriate. However, they had added wording to their referral letters in 2012 asking hospitals to inform them if they did not consider that a patient's referral was necessary.

Information sharing

The practice had a process for making sure test results and other important communications about patients were dealt with promptly. Practice staff had written guidance and instructions to help them follow the expected process for this. The GPs recorded details about normal test results so that reception staff could provide this information to patients.

The practice had systems for making information available to the out of hours service about patients with complex care needs, such as those receiving end of life care.

The practice was in the process of introducing the electronic Summary Care Record and planned to have this fully operational within a few weeks. (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 delayed implementing this

Good

Are services effective?

(for example, treatment is effective)

due to computer system problems which they wanted to resolve to avoid patient dissatisfaction once it was in use. They had plans to inform patients about the system once it was in place and ready to use.

The practice was aware of legal requirements in respect of patients' confidential information and information for patients about this was available in the practice leaflet.

Consent to care and treatment

The practice had a policy to support staff in fulfilling the requirements of the Mental Capacity Act 2005. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. This reflected national and local guidance and provided links to government and voluntary organisation information to support best practice. The policy included information about how patients who did not speak English as a first language might need additional support to be able to give consent.

The practice consent policy provided guidance for GPs and nurses with duties involving children and young people under 16 in respect of the need to consider Gillick competence. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The GPs and nurses we spoke with understood the importance of gaining informed consent. All of them described the principles and processes involved in a knowledgeable way.

We met a GP registrar who had recently started at the practice. A GP registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. The registrar had been sitting in on appointments with experienced GPs at the practice. They were aware that the reception team had been asking patients if they were happy for the registrar to be present during their appointment. They felt that this worked well because it gave patients time to consider this before going in to see their GP.

Health promotion and prevention

We discussed health promotion with a practice nurse. They told us that the practice did not generally hold specific clinics with set times because they found that patients preferred to book appointments at times to suit them. This included appointments for babies and children to have their routine childhood vaccinations. However, there were some set clinics. These were for asthma and for ante natal appointments with a midwife.

Staff told us that the practice had planned ahead for the 2014 flu vaccinations and had actively targeted their patients who were over 65 or at risk due to a long term health condition. They held three 'walk-in' flu vaccination clinics during November 2014 and arranged individual appointments for patients not able to attend on the clinic days. The clinics were held in the afternoon and evenings to provide flexibility for patients unable to attend during the main part of the day. The practice informed us that 64.1% of patients over 65 had received a flu vaccination and 31.5% had completed disclaimers because they had declined to have this done. Their figures for patients in at risk categories for flu were lower with 44.8% having had the vaccine and 12.27% declining to do so.

The practice had provided a 'Body stat' self-service machine in the waiting room. Patients could use this to check their weight, blood pressure, height and body mass index. They could print the results of this to refer to and to be logged with their medical records. The practice hoped that this would help patients monitor these aspects of their own health.

The practice website provided links to wider NHS guidance and advice about health related matters. This included the NHS Choices website A to Z. Other specific guidance was also available on the website including information about termination of pregnancy.

The practice offered a health check with the health care assistant or practice nurse to all new patients registering with the practice. Patients with complex care needs or who were prescribed repeat medicines were also booked in to see a GP. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

Post natal checks for mothers at six weeks after delivery were provided by a GP who also carried out six week baby checks. The practice provided childhood vaccinations and the take up for various different vaccines was between 97% and 100% for the children registered with the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2013/14 national patient survey information we reviewed showed patients responded positively to questions about their overall experience of using the service and treating them with care and concern. Of practice patients who responded 92% described their overall experience as good or very good and 90% and 92% respectively said their GP or nurse was good or very good at treating them with care and concern. The practice's patient participation group carried out a patient survey each year. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. In 2013/14 the results had improved from previous years and showed that 51% of patients thought the staff were very good or excellent and 27% thought they were good. Overall satisfaction results from the PPG survey were – very good or excellent 33%, good 45% and fair or poor 22%.

The patients we met during the inspection, one of whom was the deputy chair of the PPG, were positive about the practice team's approach to patient care and complimentary about the staff.

We sent CQC comment cards to the practice before the inspection. We received eight completed cards which gave us information about those patients' views of the practice. Although a small sample, the information written by patients reflected the national data and presented a positive picture of patients' experiences. Patients' comments included words such as compassionate, caring, supportive, friendly, obliging and understanding.

During 2014 the practice arranged a course in customer care for receptionists, administration staff and secretaries to ensure they deal with patients, effectively, appropriately and politely.

The staff we met during the inspection showed a commitment to their role and spoke about patients in a respectful way.

Care planning and involvement in decisions about care and treatment

Some patients mentioned in comment cards that their GP listened to them, made sure they understood the cause of their illness and explained the treatment they needed clearly. Several patients described being very satisfied with the care, treatment and support the practice gave them.

The 2013/14 national 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, 90% of practice patients who took part said the GP involved them in care decisions. The 2013/14 patient survey carried out by the PPG also gave a positive view of the service provided.

Staff told us that translation services were available for patients who did not have English as a first language but that they rarely needed to us this. The practice's consent information included a reminder that patients who did not speak English as their first language may need additional support in respect of making decisions about treatment and giving consent.

Patient/carer support to cope emotionally with care and treatment

The information contained in the comment cards showed that patients felt supported by the practice. Four of the cards contained specific information about the support patients received from their GP over a long period of illness or during a medical emergency. We met a patient who was also a carer. They told us that the practice was supportive of the family members they cared for and attentive to their care. They were also understanding and supportive to them as a carer and took this into consideration when they needed an appointment for themselves.

Information about sources of support and guidance for patients and those close to them was available on the practice website and at the practice.

There was a carers' policy based on local and national guidelines. This contained links to information about local and national carer organisations. The practice had carers' toolkit – a resource to help them identify and communicate with carers. This included a poster, information about services, carer registration forms and standard letters informing carers of the services that might be available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

All of the GPs at Springhill Medical Centre specialised in one or more health care areas. This enabled the practice to offer a range of services to patients of all ages and across all population groups. The practice population included high numbers of working age female patients. One of the female GPs specialised in women's health including contraception, contraceptive coil fitting and removal and contraceptive implants. Another GP specialised in the care of patients with diabetes. Other services provided at the practice included joint injections, minor surgery and cryotherapy.

The female GP with a particular interest in women's health carried out a procedure called endometrial biopsy. This is a procedure used to diagnose specific conditions linked to painful and heavy periods and would normally be carried out in a hospital. Patients at the practice were therefore receiving this service locally and without needing to be referred to a hospital and wait for an appointment.

A midwife held ante-natal appointments at the practice and the GPs provided six week baby checks. The practice nurses carried out childhood immunisations and new mothers could have their post natal checks at the practice.

The practice described an initiative which they had introduced to assist patients with cancer, autism, significant incapacity and those using oxygen to obtain prompt appointments. The scheme was introduced to take into account of the particular needs of those patients. This included the specific risk of infection for cancer patients during periods of receiving chemotherapy. The scheme involved patients being flagged on the practice computer system as 'purple patients'. The practice had made a commitment that these patients could expect continuity of care by seeing the same GP for their appointments. The practice also provided same day appointments for them and as far as possible accommodated their preferred time. 'Purple patients' or their carers could also be offered a side room to wait in until their GP called them if their circumstances made this necessary.

The practice used the gold standard framework for end of life care and had a register of patients receiving palliative care. The practice took part in quarterly meetings with other professionals involved in caring for patients in these circumstances. They had a system for making sure members of the team, including reception staff were aware of patients who were at the end of their lives and might need an urgent response from the team.

The practice provided electrocardiograms (ECG) using their own ECG machine and staff. An ECG records the electrical activity of the heart and can help find the cause of symptoms such as palpitations or chest pain. They also hosted clinics run by staff from the local NHS hospital trust to screen for abdominal aortic aneurysm (AAA). An aortic aneurysm is a dangerous swelling of the main blood vessel that runs from the heart, down through the abdomen to the rest of the body. This enabled patients to have these checks at their local practice rather than waiting for hospital outpatient appointments.

People over 75 had a named GP and were offered annual health checks and more specific assessments to assess their level of frailty and risk of dementia. The practice did not carry out routine blood tests at the practice but if any older patients were unable to go to the hospital for this one of the practice nurses visited them at home for this. The practice also did home visits for to provide flu vaccinations and health checks for older patients not able to visit the practice.

The team were alert to the complex needs of people who were living with dementia and had a dementia register. The practice reviewed these patients' needs at least annually. They were providing dementia screening tests and offered patients the option of being referred to the memory clinic if the result suggested they might be at risk.

The practice had a register of patients with learning disabilities and provided annual health checks for them.

The practice had a register of patients with mental health needs and provided annual health checks for them. The practice referred patients who might benefit to the Improving Access to Psychological Services (IAPT) team who visited the practice three times a week to provide a counselling service.

The practice provided temporary primary medical care for a small number of patients at a local shelter for people recovering from alcohol and drug dependency. They registered these patients as temporary patients.

Tackling inequity and promoting equality

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff at the practice had all completed equality and diversity training during 2013. We did not identify any suggestion of discrimination on any grounds during the inspection.

At Springhill Medical Centre the GPs' and nurses' rooms were on the ground floor and there was level access into the building from the car park. The car park had disabled parking spaces near to the main entrance. Part of the reception desk was low level to enable patients using wheelchairs to speak with staff at their eye level. The practice leaflet described similar arrangements at Galley Common, the branch surgery. The leaflet invited any patients with disabilities to contact them if they encountered any difficulties with access at either building.

Staff told us that the practice did not have any homeless patients or traveller families registered with them but would respond as needed as when necessary.

The practice had access to a telephone interpreting service for any patients who were unable to converse in English but staff told us that they did not need to use this very often. The practice website had a translation service which patients could use to translate all of the content into their preferred language. GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this. However, staff told us that the practice population was not culturally diverse and so whilst these facilities were available they did not need to use them often.

The practice had an induction loop to assist people who use hearing aids. The website also had a facility for patients to adjust the font size to assist patients with visual problems.

There was a prayer room in the building which was available for patients or staff to use.

Access to the service

The practice had an information leaflet and practice website providing a range of information about the team at the practice, opening times, the appointment system and internet booking.

The practice's main opening hours at both Springhill and Galley Common were 8am to 12.30pm and 1.30pm to 6pm Monday to Friday. On one day a week the practice provide appointments from 7am and from 6.30pm to 8.30pm on two days a week. Patients unable to go to the practice during core hours (for example, those at work during the day) were given first choice for these appointments. Not of all of the extended hours were advertised on the practice website which limited the information available to patients and could lead to confusion.

We spoke with a patient during the inspection who told us that they had been able to arrange an appointment at 7.10am which had been very helpful to them because they were at work during the day. They also said that if they wished to see a particular GP they were usually able to get an appointment within a few days.

Patients could book same day appointments and could also book an appointment up to two weeks ahead. Some appointments could also be made up to three months in advance. The practice told us that their policy was to see any patient needing an urgent appointment on the same day no matter what time of day they telephoned. We noted that on the day of the inspection only two bookable spaces remained for the next three days; however we saw evidence confirming that patients with an urgent need were given same day appointments. Reception staff we spoke with confirmed that there was no cut off time if a patient needed to be seen on the same day. They told us that if someone phoned before the practice closed at 6.30pm a GP would see them.

The practice had a duty GP system. The duty GP saw patients needing urgent same day appointments and also provided telephone triage to assess the need of patients to be seen urgently.

Patients could book appointments by telephone or by calling at the practice. They did not currently have a facility for booking appointments online.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

The complaints procedure was supported by forms for patients to complete if they wished to raise a concern about the practice. These were available in reception and the reception team were aware of the procedure and their role in responding to patients who had concerns. We

Good

Are services responsive to people's needs?

(for example, to feedback?)

looked at two complaint records. These showed that the practice had investigated these well. The practice had kept comprehensive records about these and provided the patients concerned with prompt responses and apologies.

A GP we spoke with about complaints told us that the practice aimed to respond to all complaints within 48 hours.

The practice had begun to offer face to face discussions with any patient who made a complaint about the service to provide a more personal approach and to foster positive relationships with patients.

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

Springhill Medical Practice had moved into new, purpose built premises in 2012. They had created a practice logo which they explained represented the history and natural environment of the area and the transition to the new premises. The practice website described the practice's aim as being to deliver excellent patient care, with continuous focus on quality whilst offering a wide range of enhanced services. The practice recognised that it was a key service for the semi-rural area it served so kept local people informed during the development of the new practice building in 2012. They had developed links with local schools and involved the pupils in the interior colour schemes. School children and a local artist had produced artwork displayed in the practice building.

The practice was aware that planned additional housing in the area was likely to have an impact on their patient numbers and that this was a concern for local people. They had recognised that they needed to plan for the future and manage their resources effectively alongside patient expectations.

The GPs explained that plans for the future of the practice included the likelihood of forming a federation with 28 other practices. They believed that this would improve the sustainability of the practice by sharing resources and skills and creating income streams for the practice. An example of this was the potential for providing minor surgery services for other practices. The practice was also planning to host student nurse placements at the practice.

The practice had a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care. The group had been established for 12 years. The PPG was working with the practice to help them plan for the future of the practice and identify the services patients needed for the future.

The practice did not have regular routine meetings involving the whole team so did not have a structured route for sharing information with all staff about the vision and strategy for the future of the practice.

Governance arrangements

The practice had a range of policies and procedures and these were all available on the practice computer system where all members of the team could access them. All of the staff we met understood their roles and responsibilities within the practice.

We learned that the practice had weekly partner meetings. In 2012 there had been an 'away day' for all staff but this exercise had not been repeated. We saw notes of staff meetings in October 2013 and January 2015 and noted that the partners did not attend these. There were no routine or regular opportunities for the whole staff team to meet and discuss the running of the practice together. The practice manager described working closely with one of the partners in particular. They valued the support from this partner and recognised that there would be value in providing more opportunities for the whole team to learn and develop together.

The practice used a specialist human resources company to support them in respect of all aspects of staff management.

Leadership, openness and transparency

We met a GP registrar who had been at the practice a few weeks. A GP registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. The registrar told us that they had had a very positive experience since arriving at the practice. They described feeling welcomed and supported by team and said that they felt able to approach any of the GPs for advice or support.

The deputy chair of the PPG told us that the practice was open when anything went wrong. They were confident that the practice would not hide anything of concern but would deal with it in an open way.

The practice had recognised that their internal communication processes were an area which they needed to develop and improve.

Practice seeks and acts on feedback from its patients, the public and staff

The practice invited the deputy chair of the PPG to their presentation at the start of the inspection. We then met with them to speak with them about the way the practice promotes the PPG and responded to the input from its

Are services well-led?

Good

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

members. They told us that the PPG viewed its role as being a 'critical friend' to the practice. They told us that the practice manager always attended the PPG meetings and was well prepared for these. They explained that the group was active and vocal and that the practice was open to their involvement and took notice of the views they expressed. They told us that communication with the practice had improved significantly and that the practice was increasingly open to discussing issues with the PPG. Meetings were held at the practice in an evening four or five times a year. Patients not able to attend the meetings could still take part in the PPG by email.

We saw that the practice had information about joining the PPG and about the work it did on the practice website. This included a detailed report showing changes already made following patients' feedback and those planned for the coming year.

During the inspection we heard about changes and improvements the practice had made in response to the PPG's suggestions. These included improvements to the electronic prescription service and arrangements for patients to obtain appointments with their preferred GP without waiting too long. The PPG had also asked the practice to review how arrangements for deciding which patients needed to be seen urgently worked. The initiative to introduce a 7am surgery one day a week had originated with discussions with the PPG. In February 2015, shortly before the inspection, the practice upgraded the telephone system to make it easier for patients to telephone the surgery. PPG members had also asked for all of the GPs to be available for appointments at Galley Common, the branch surgery as well as at the main practice. The practice had changed the GPs' rotas to accommodate this. The PPG was positive about the future of the PPG; they found that the GPs were willing to ask for PPG members' views about how to solve problems and improve the service.

In addition to the PPG the practice had introduced a 'Share your experience' email address on its website in 2012 to provide an additional way for patients to communicate with the practice.

Management lead through learning and improvement

The practice had recognised that they needed to develop and improve to provide a service that met the needs of an increasing population into the future. They were open to suggestions from the PPG and had taken a learning approach to some of the issues they had raised. For example, to help them improve the telephone and appointment systems at the practice some of the GPs had visited other practices to see how they did this.

The practice showed us their plan for ensuring all staff received a performance appraisal with dates set for these to be completed for all non-clinical staff by the end of February 2015. The practice manager explained that they had completed few appraisals during 2014 due to being away for part of that year. We saw an example of a completed staff appraisal for. This used a comprehensive format and contained suitable information.

One of the GPs told us they provided training for GPs and practice nurses in respect of family planning and contraception.

Members of the practice team had regular protected learning time to enable them to take part in training to contribute to their continuous professional development (CPD). We saw that the practice had a half day each month booked for this and that these dates were on their practice website to inform patients of when the practice would be closed.

During the inspection we gathered information that showed that the practice recorded and investigated significant events and complaints. We also saw that specific issues had been acted on. However, apart from weekly partner meetings, practice meetings were held at varying frequencies and were for separate staff groups rather than for the whole staff team. Because of this the practice did not have a cohesive way for the whole team to learn and develop together.