

Chestnuts Park Medical Practice

Quality Report


The Laurels Healthy Living Centre
256a St Ann's Road
London N15 5AZ
Tel: 0203 224 4499
Website: www.chestnutsparksurgery.co.uk

Date of inspection visit: 28 January 2015
Date of publication: 10/09/2015

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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	10
Background to Chestnuts Park Medical Practice	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Chestnuts Park Medical Practice on the 28 January 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 service.

It was also good for providing services to the six population groups - older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

The practice has been run by the Hurley Clinic Partnership. Hurley took over the service in 2013. Prior to that, following action by service commissioners over concerns with performance and patients outcomes, three other providers had operated the service in the preceding three years. A number of the non-clinical staff at the practice had worked for the previous providers, later

being transferred to the succeeding providers and eventually to Hurley. Hurley had recognised that staff morale was low as a consequence and had carried out various successful teambuilding exercises. Patients told us that the service had improved since Hurley took over the service and the practice was continuing to work with commissioners to further develop and improve performance.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- There was a clear leadership structure, vision and strategy.
- The practice proactively sought feedback from staff and patients, which it acted on.

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

The practice should

- Put into place an effective system to ensure that an accurate record is maintained regarding the use of medicine fridges and temperature monitoring.
- Review and update the infection control policy, identifying the lead staff member responsible.
- Introduce a system for carrying out regular clinical audit cycles to monitor performance and identify where improvements may be made to the service and patient outcomes.
- Consider opportunities for employing more male GPs to improve outcomes for male patients, who may be unwilling to see female doctors.

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?

The practice is rated as good for providing safe services as there are areas where it should make improvements.

Patients' needs were assessed and care was planned and delivered in line with best practice current guidance. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. The practice used a range of information to identify risks and improve patient safety. The practice received National Patient Safety Alerts and these were passed appropriately to staff.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Information about safety was recorded, monitored, appropriately reviewed and addressed. However, records regarding the use of medicine fridges and temperature checks were incomplete. Risks to patients were assessed and managed. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Data showed patient outcomes were at or below average, for example relating to cervical screening and flu vaccination rates. However, the practice was working with service commissioners to improve these.

Although clinical audits had been done, there was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes.

All permanent GPs at the practice were female, which may impact on outcomes for male patients who may prefer to see male doctors.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible.

We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. It had an active Patient Participation Group, monitored patients' comments left on the NHS Choices website and patients were encouraged to make suggestions.

Feedback from patients reported that accessing the service was sometimes difficult, but the practice was taking steps to improve performance. The practice was equipped to treat patients and meet their needs.

Patients could get information about how to complain in a format they could understand. Learning from complaints was shared with staff and other stakeholders.

Although male locums were sometimes available, the lack of permanent male doctors may impact upon outcomes for male patients who may be unwilling to see female doctors.

Good



Are services well-led?

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. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

There were systems in place to monitor and improve quality and identify risk, although there was a need to ensure that completed clinical audit cycles were carried out to drive improvement in performance to improve patient outcomes.

Good



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

The practice is rated as good for the care of older people.

The practice offered proactive, personalised care to meet the needs of the older people. It offered a range of services including palliative and end of life care, to improve outcomes for patients. It was responsive to the needs of older people. Care was taken to allocate older patients to their usual GP, or locums with whom they are familiar. It offered home visits for those patients who were not able to attend the surgery, liaising appropriately with any carers involved. The practice had monthly meetings with the district nursing team and community matron to discuss patients' needs. All patients aged over 75 had named GPs.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

The practice kept a register to monitor the health of patients with known long-term health conditions. 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. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people.

All new mothers were invited in for post-natal screening. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances, children who had frequently missed appointments and those with identified health conditions such as asthma. There were monthly meeting with the health visitor to discuss issues of concern.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and to offer continuity of care. For example telephone consultations were available and extended hours offered a wider choice of appointment times. Patients could book their appointments and order repeat prescriptions on line.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice maintained registers of patients living in vulnerable circumstances, such as those with learning disabilities, and a register of carers so that patients' healthcare needs could be monitored and reviewed.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to inform staff of any relevant issues when patients attended appointments, for example patients with limited capacity.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice ensured that regular reviews and appropriate blood tests are carried out to monitor patients' medication. The practice liaised with relatives and carers appropriately. The practice regularly worked with multi-disciplinary teams in the case management of people in this population group. The electronic record system would flag up if vulnerable patients were attending for an appointment so that staff members were aware of any relevant issues.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with 11 patients including members of the practice's Patient Participation Group. We reviewed eight completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. We looked at information published on the NHS Choices website and the 2014 National Patient Survey results, being the latest available at the date of the inspection.

The evidence from all these sources showed that patients were generally happy with the service provided in terms

of the practice being caring. They said they were treated with dignity and respect, that the practice involved and supported them in decision making. Most spoke very highly of the GPs.

A number of patients had recorded their concerns over the practice's appointments system and problems getting through by phone. However, patients recognised that the practice had been responsive to their comments and complaints and it had sought to improve the service.

Areas for improvement

Action the service **SHOULD** take to improve

- Put into place an effective system to ensure that an accurate record is maintained of fridge temperature monitoring.
- Review and update the infection control policy, identifying the lead staff member responsible.
- Introduce a system for carrying out regular clinical audit cycles to monitor performance and identify where improvements may be made to the service and patient outcomes.
- Consider opportunities for employing more male GPs to improve outcomes for male patients, who may be unwilling to see female doctors.

Chestnuts Park Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. It included a GP, a practice nurse, a practice manager and an expert-by-experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. They were all granted the same authority to enter Chestnuts Park Medical Practice as the Care Quality Commission (CQC) inspectors.

Background to Chestnuts Park Medical Practice

Chestnuts Park Medical Practice operates from The Laurels Healthy Living Centre, 256a St Ann's Road London N15 5AZ, premises it shares with various other healthcare providers, including another general practice and a pharmacy.

The practice provides NHS primary medical services through a Personal Medical Services (PMS) contract to approximately 4,900 patients in Haringey, north London. The practice is part of the NHS Haringey Clinical Commissioning Group (CCG) which is made up of 51 general practices.

The practice has been run by the Hurley Clinic Partnership since July 2013. Hurley operates 22 locations across London. The practice is registered with the CQC to provide the regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services, and the Treatment of disease, disorder or injury.

The clinical staff at the practice was made up of three GPs, all female. The practice's one nurse had recently left and the nursing duties were being covered temporarily by Hurley's corporate nurse team. In addition, there was a practice manager and an administrative team of five. The practice manager had started very recently and additional management and administrative support was being provided by the Hurley Clinical Partnership corporate team.

The practice opening hours were 8.00am to 6.30pm Mondays and Fridays; 8.00am to 7.00pm on Tuesdays, Wednesdays and Thursdays. The phones were answered from 8.00am to 6.30pm Monday to Friday. The practice had opted out of providing out-of-hours (OOH) services and had a contract in place with the local OOH provider. When the practice was closed, callers were referred to NHS 111, which triaged the calls and passed them to the OOH provider as appropriate.

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.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- 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)

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS Choices website and the National Patient Survey and asked other organisations such as Healthwatch, NHS England and the NHS Haringey Clinical Commissioning Group (CCG) to share what they knew about the service. We carried out an announced visit on the 28 January 2015.

During our visit we spoke with a range of staff including GPs, the nurse and non-clinical staff. We also spoke with members of the Hurley Clinical Partnership corporate team who were providing additional management and administrative support. We spoke with 11 patients, including members of the practice's Patient Participation Group. We reviewed eight completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service.

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. QOF is a national performance measurement tool, which is used to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services.

Are services safe?

Our findings

Safe track record

The practice had systems in place to identify risks, but we had some concerns about the way the practice managed patient safety. For example, relating to medicines management, infection prevention and control and fire safety. Reported incidents and significant events both at the practice and at other Hurley locations were monitored and comments and complaints received from patients were acted upon. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the twelve months. This showed the practice had managed these over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of nine significant events that had occurred during the last two years and saw this system was followed appropriately. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Significant event reporting was a standing item on the monthly operational meeting agenda and learning from significant events was included in the Hurley's newsletter which was distributed to each practice. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue with managers for consideration at the meetings and they felt encouraged to do so.

Staff completed and sent standard incident forms to the practice manager. We saw that records were completed appropriately, in a timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, when a delay occurred in arranging a patient's appointment following an X-Ray, an appropriate timescale for carrying out urgent and non-urgent administrative tasks was introduced. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated to practice staff using the NHS Central Alerting System. This is a

web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. The practice had appointed one of the GPs as safeguarding lead. We looked at training records which showed that the clinical staff had received appropriate level training in safeguarding children and after the inspection the practice gave us evidence that adult safeguarding training had been also been provided. Adult and child safeguarding training was given to non-clinical staff as part of their induction. We saw in minutes of a recent reception team meeting that staff had been instructed to complete all mandatory refresher training, which included adult and child safeguarding, without delay. The practice later provided evidence that the refresher training had been completed by staff.

Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. There was active engagement in local safeguarding procedures, copies of which we saw available at the practice for staff to follow, and effective working with other relevant organisations including health visitors and the local authority. This included frequent attendance by GPs at child protection conferences and reports being sent if staff were not able to

Are services safe?

attend. The practice's electronic records highlighted other vulnerable groups, such as homeless patients, to make staff aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and was displayed for patients to view. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. We found that no specific training had been provided to staff undertaking chaperone duties. The practice told us that the training would be arranged and after the inspection the practice gave us evidence that the training had been done. Some non-clinical staff, who had transferred from the previous service provider, acted as chaperones when necessary. Although Disclosure and Barring Service (DBS) checks had been done in relation to these staff by the previous service provider, the practice could not provide evidence that DBS checks had been had been repeated, or that suitable risk assessments had been carried out in relation to the role of chaperone. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. However, we saw evidence that all staff had been instructed at a recent staff meeting to apply for the checks and provide suitable proof of doing so to Hurley's human resources department. The practice confirmed after the inspection visit that all staff DBS checks had been completed.

Medicines management

We checked medicines stored in the treatment rooms and medicine fridges and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We looked at records of fridge temperature checks and noted a number of gaps. For example, between the 20 and 29 October 2014, one of the fridges had not been checked. The practice told us that this was because the fridge had not been in use during that period, but this had not been clear in the records. There were other instances when monitoring had not been done for four consecutive days, including weekends. However, there was no evidence to indicate that the fridge

temperatures had exceeded the required range. Failings regarding fridge temperature monitoring had been investigated by practice management and had led to disciplinary action being taken against a member of staff.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. No controlled drugs were kept at the practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. There was a pharmacist, with whom we spoke, at the premises. They told us there had been no concerns with prescriptions issued by the practice.

We saw meeting records confirming that prescribing data was reviewed, for example relating to Vitamin D prescribing, which highlighted good prescribing practice in accordance with Haringey CCG guidelines.

Cleanliness and infection control

We observed the premises to be generally clean and tidy, although we found that the tops of cupboards in some of the consultation rooms were dusty. We saw no schedule for changing disposable curtains in the consulting rooms and the curtains had not been dated when put up. In addition, we found instruments and equipment that were passed their use by dates. These were removed by staff when we drew their attention to them. After the inspection, the practice confirmed that a process had been introduced for staff to monitor instruments and equipment on a monthly basis. The practice also said that the dates when the curtains were put up had been recorded on the curtains and on a list fixed on the wall for easy monitoring.

Most of the patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. However, three patients told us that the toilets were often dirty and soap and paper towels were sometimes not available. We inspected the four toilets and noted they were adequately stocked with soap and paper towels, but we saw that sanitary bins were overflowing with used paper towels, with paper towels littering the floors,

Are services safe?

and there was no toilet paper in the disabled toilet. Notices about hand hygiene techniques were displayed. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We were told that the landlord was responsible for cleaning and waste management. The practice did not have any cleaning schedules or checklists for us to see. Staff told us that the practice had discussed cleaning issues with the landlord before, for example at premises “tenants” meetings, although we did not see evidence of this. The day after the inspection, we received confirmation from the practice that it had again raised our concerns with the premises landlord and had been given assurances that they would be addressed. Subsequently, the practice informed us that there had been a marked improvement with the cleaning and it provided evidence of cleaning rounds being done three times a day. We saw evidence that an infection control audit had been carried out by the landlord in December 2013, meaning a repeat audit was slightly overdue. We were told that the landlord would be carrying out another infection control audit in early February 2015 and the practice later confirmed that this had been done on the 19 February.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The policy was dated September 2013 and was therefore in need of review. For example, it stated that the practice nurse was the infection control lead, but there had been no permanent nurse since in post for several months and it was not clear who the responsible person now was.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice’s infection control policy. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We were told that the landlord was responsible for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). However, records of regular checks to reduce the risk of infection to staff, or evidence of a risk assessment for legionella being carried out were not available for inspection. The practice later provide evidence that the legionella risk assessment had been carried out on behalf of the landlord in November 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all electrical and mechanical equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely (PAT) tested and displayed stickers indicating the last testing date which was 19 February 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, ear syringe, blood pressure measuring devices and the fridge thermometer being calibrated at the same time as the PAT testing.

We found instruments and equipment that were passed their use by dates. These included coil removers and chlamydia swabs that expired in November and December 2014 and syringes that expired in August 2014. We brought this to the practice’s attention and received an assurance that all out of date instruments would be disposed of immediately. The practice later confirmed that system of monthly monitoring had been introduced.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The majority of non-clinical staff had transferred to Hurley from the previous service provider at the location. Recruitment records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice confirmed after the inspection that DBS checks for non-clinical staff had been repeated, as appropriate for staff performing chaperone duties.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us there were usually

Are services safe?

enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

There were systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had health and safety risk assessments in place and where risks had been identified control measures were in place to minimise them. Plans were in place to manage staff shortages including the use of locums to cover staff absence due to illness, annual leave or maternity leave.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available at the premises, including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of

this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. However, we found that not all staff had received training in basic life support in the preceding two years. After the inspection, the practice provided evidence that this refresher training had been given to all staff.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan had been reviewed in June 2014 and again in January 2015.

The premises landlord had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. There were weekly fire alarm tests, carried out by the premises landlord. At the inspection, there was no evidence to show that staff were up to date with annual fire safety training or that they practised regular fire drills. However, the practice later gave us an assurance that the training had been completed by all staff and that drills were conducted regularly. It also informed us that another fire risk assessment had been carried out by the landlord in January 2015.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and discussed at clinical meetings and we saw minutes to confirm this. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. We looked at 10 patients' healthcare records, including patients with long term conditions. The records showed that regular health checks were carried out by GPs, with appropriate referral of patients to other services. Feedback from patients confirmed they were referred to other services or hospital when required.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. This was done either by phone, appointment at the surgery or a home visit.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. The practice showed us three clinical audits that had been undertaken over the previous year. One of the audits related to Warfarin prescribing and led to the practice's prescribing protocol being revised to ensure that prescribers followed the NPSA guidance. The audit was due to be repeated shortly after our inspection. Another audit, relating to Methotrexate prescribing, led to the introduction of a recording template which will aid clinicians in recording information needed for safe prescribing. Although we saw that the Warfarin audit was due to be repeated, there was no evidence of completed audit cycles being done by the practice.

We saw that performance monitoring was a standard agenda item for practice meetings. The practice monitored information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The CQC looks at QOF information as part of its monitoring of GP service. We noted that there was no QOF information published on the Health and Social Care Information Centre website. Staff told us that this was due to problems stemming from when the previous provider at the location had ceased to operate. This had resulted in a coding error, which meant that figures submitted were not recorded. However, the practice provided us with QOF information it had produced. The practice monitored this information and other data to check on performance. This included information collected by Hurley relating to all its locations for comparison. The practice monitored patients' comments left on the NHS Choices website. The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. These were discussed at practice meetings and were responded to appropriately.

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

Are services effective?

(for example, treatment is effective)

The practice's prescribing rates were similar to national figures, presenting no evidence of risk. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, such as those with learning difficulties. Structured annual reviews were also undertaken for people with long term conditions, for example diabetes.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed a number of staff files including both clinical and non-clinical staff held on the Hurley computer system. They demonstrated that staff had the appropriate skills and qualifications to meet patients' needs. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England. The permanent GPs at the practice were female. This might present concerns for male patients unwilling to see female doctors. Male patients could ask to see male locum doctors, if there were appointments available.

All staff completed an induction programme when they started working for the practice, in accordance with the Hurley corporate induction policy, which we saw. The induction included mandatory training in a wide range of topics, such as health and safety, equality and diversity, basic life support, child protection, safeguarding adults, infection control, information governance and computer training. We looked at a number of staff records and saw that

staff received mandatory training as part of their induction. This included staff who had transferred from the previous service provider. However, there was no evidence that all staff had received suitable, refresher training in areas such as safeguarding adults and children, basic life support and fire safety. After the inspection, the practice provided evidence that safeguarding and basic life support refresher training had been given. Although we saw that most had had annual appraisals done, some staff members told us that their appraisals were overdue.

Working with colleagues and other services

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 hospitals including discharge summaries and the NHS 111 service and out-of-hours service provider, both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of-hours and NHS 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were in line with the national average. The practice was not commissioned for the unplanned admissions enhanced service which requires an enhanced level of service provision above what is normally required under the core GP contract. We saw that the policy for actioning hospital communications was working well in this respect. The practice monitored follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by the community matron, district nurses, social workers, and health visitors and decisions

Are services effective?

(for example, treatment is effective)

about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used an electronic system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence confirming that the completeness of these records was monitored and discussed at practice meetings to identify and address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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

did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers, which patients confirmed when they spoke with us.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 94% of patients in this age group took up the offer of the health check. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 90% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 86% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 71%, which was below the CCG average of 94%. The practice was aware of this low rate of screening and was working with service commissioners to improve uptake of the screening. There was a policy to contact patients who had not attended for their cervical screening

Are services effective?

(for example, treatment is effective)

test and was working on ways to increase screening uptake. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was below average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 63.6%, and at risk groups 41.98%. These were approximately 10% below national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 80.7% to 89%, being slightly below the CCG average, and five year olds from 85.6% to 93.8%, slightly above the CCG average.

The practice was aware of these rates and was working with service commissioners to improve immunisations uptake.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included comments left by patients on the NHS Choices website, information from the latest available national patient survey, published in January 2015, and a survey of patients undertaken by the practice in February 2014 and presented to the Practice Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice performance being below the CCG average and national averages. For example,

- 79% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 72% said the GP gave them enough time compared to the CCG average of 81% and national average of 87%.
- 88% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%

Patients completed CQC comment cards to tell us what they thought about the practice. We received eight completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service, which was efficient and effective. One patient described the staff as professional, friendly and helpful. Patients said staff treated them with dignity, compassion and respect. One of the comments cards referred to reception staff being rude and unfriendly and we had seen similar comments left by patients on the NHS Choices website. However, we noted that the premises had one large reception desk, which the practice shared with the other GP practice and various other services which operated at there. From our discussions with patients and our observations, it became evident there was confusion over the layout of the reception area and reception staff working for some of the other services were sometimes mistaken for those of the Chestnuts practice. One patient,

speaking of the Chestnuts receptionists, said they were always friendly and helpful. Another said they were very kind. All patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that patients could go to a quiet waiting area or use one of the consulting rooms available to discuss confidential issues. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We spoke with the manager of a local care home, whose residents are on the practices' patients list. They told us that the GPs and receptionists were very good with those patients with dementia.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded generally positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 81% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 71% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 81%.

Are services caring?

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. We saw evidence in health records of patients with long term conditions confirming their involvement and agreement in discussions regarding their care plans. We saw evidence of appropriate end of life planning in patients' records.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and evidence on patients' records of the service being used.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice, with 77% saying the last GP they spoke to was good at treating them with care and concern

compared to the CCG average of 80% and national average of 85%. However, patients were less positive regarding their experience of nurse appointments. Sixty per cent said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 90%. Some patients told us that there had been a high turnover of nurses working at the practice, which might account for this. At the time of the inspection, the nurse duties were being carried out by the Hurley corporate nursing team, several of whom covered the practice. The practice was in the process of recruiting a permanent nurse.

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation to provide advice on how to find a support service. No patients we spoke with had had bereavement, but we saw evidence which confirmed the practice provided this type of support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The general needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. However, all the GPs at the practice were female which may present some concerns for male patients wishing to see a male doctor. Although male locums were sometimes available, the lack of permanent male doctors may impact upon outcomes for male patients.

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

The practice had an active Patient Participation Group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with representatives of the PPG who explained their role and how they worked with the practice. The PPG consisted of approximately eight members, four male and four female patients between the age of 25 and 74 years old. The PPG met with the practice staff and was involved in the patient survey conducted in 2014. The practice had formulated an action plan in agreement with the PPG and some areas for improvement had been implemented. For example, following concerns regarding the ease of getting an appointment, the practice had introduced a telephone triage and call back system, so that patients could speak with GPs for advice, without the need to attend the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. In addition, special telephone arrangements were made for residents of a nearby care home to allow the carers to contact the practice quickly in urgent cases. The majority of the practice population were

English speaking patients, but access to online and telephone translation services were available if they were needed. The practice had a policy to "welcome all comers" and encouraged asylum-seekers and homeless people to register as patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice opening hours were 8.00am to 6.30pm Mondays and Fridays; 8.00am to 7.00pm on Tuesdays, Wednesdays and Thursdays. The extended hours made appointments available outside of school hours for children and young people and were convenient for working age patients. An online appointment booking system could be accessed via the practice website. Patients could arrange telephone consultations with GPs. One of the patients we spoke with had done so and told us it worked well. In addition, there was an online consultation service allowing patients to submit a short questionnaire, which would be reviewed by a GP and responded to by phone by the end of the next working day. An online prescription service was also available and prescriptions were processed within 48 hours.

The practice had opted out of providing out-of-hours (OOH) services to patients and had a contract in place with the local OOH provider. Callers were referred to NHS 111 service, which triaged the calls and passed them on to the OOH provider as appropriate. Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received

Are services responsive to people's needs?

(for example, to feedback?)

urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Routine appointments were available for booking two weeks in advance. Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available to those who needed them. These included GPs visiting a local care home, whose residents were patients of the practice, although there were arrangements in place with the home for most patients to attend the practice.

We looked at the patient survey information relating to access to appointments. We saw that 72% were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 75%. However, patients had responded negatively to other questions regarding access, for example -

- 57% described their experience of making an appointment as good compared to the CCG average of 78% and national average of 85%.
- 54% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 59% and national average of 65%.
- 29% said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 73%.

This was borne out by patients we spoke with, a number of the comments cards and patients' comments on NHS Choices. Patients told us that although things had improved, it was still sometimes difficult to get through to the practice by telephone, with often a long wait before the call was answered. We discussed the matter with staff and were told that the telephone system was shared with other services operating at the premises. Problems with the system had existed for some time and had been discussed frequently with the premises landlord. Some of the problems were caused by technical issues with the system, which included callers being disconnected when they reached the head of the queue. We saw evidence that the

practice was working with the landlord and the telephone system provider to resolve the problems, either by servicing the system or upgrading it. The practice had revised the administrative staff rota to ensure that there was additional telephone cover between 8.00am and 9.00am each morning and arranged for further training was being given to staff regarding operating the system.

Patients we spoke with were otherwise satisfied with the appointments system and said it was easy to use. They confirmed that they had often been able to see a doctor on the same day, if they felt their need was urgent, although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

Listening and learning from concerns and complaints

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

We saw that information was provided to help patients understand the complaints system, with leaflets available in the reception area and information on the practice's website. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint, although none had had reason to do so. Three written complaints had been received in the last 12 months, with nine the previous year. We found they were satisfactorily handled, dealt with in a timely way, openness and transparency. None had been referred to the Ombudsman.

The practice reviewed complaints to detect themes or trends. We saw that complaints were an agenda item at practice meetings which assisted in monitoring and we saw minutes confirming all staff were able to learn and contribute to determining any improvement action that might be required. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, guidelines on appointments had been revised as a result of one complaint and the practice's private fee charges clarified as the result of another.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose. The practice vision and values included working in partnership with commissioners and stakeholders and being accessible to all patients. Members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on Hurley's internal electronic system accessible on any computer within the practice. These included policies on equal opportunities, bullying and harassment, chaperoning and whistleblowing. We saw that the policies and procedures had been reviewed annually and were up to date. An electronic record showed that most staff had accessed and read the policies. Reminders were issued to staff via the system when updates were issued.

The practice had an appropriate leadership structure with named members of staff in lead roles. For example, the senior GP was the lead for safeguarding. Staff we spoke with were clear about their own roles and responsibilities and knew who to go to in the practice with any concerns.

The lead GP and practice manager, supported by the Hurley Clinical Partnership corporate team took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). Although we had not been able to access the practice's QOF data before the inspection, we were provided with it afterwards. The data showed it was generally performing in line with national standards, although not all targets were met. We saw that QOF data was regularly discussed at monthly team meetings and actions were planned to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, at the inspection there was no evidence of completed audit cycles. We saw that one audit led to the practice's prescribing protocol being revised. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice used the Hurley human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

GPs and managers were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Administrative staff had transferred from the previous service provider. The practice told us that there had been problems with staff relations following the transfer and that a lot of work had been done to improve matters. This included a team function exercise, involving interviews with individual staff and a group session, with a follow up day. Staff we spoke with said the exercise had gone well.

There were regular staff meetings and staff were given the opportunity to be involved in discussions about how to run the practice and how to develop the practice. We saw from minutes that team meetings were held regularly and staff told us they had the opportunity to raise any issues of concern. Staff told us that regular away days were being planned.

Are services well-led?

Good 

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

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice PPG included representatives from various population groups, for example British or mixed British, African, Irish and Asian, with an age range from 25 to 74. Patients registering with the practice were encouraged to join the PPG. We saw the results of the last patient survey, which had been considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We spoke with members of the PPG and they were positive about the role they played and told us they felt engaged with the practice.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service

delivered at the practice. The practice monitored comments left by patients on the NHS Choices website and responded to them. Comments were discussed at team meetings.

The practice had also gathered feedback from staff by an annual staff survey and generally through staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that the practice had an up to date policy covering clinical supervision of GPs and nurses and supervision of non-clinical staff. We looked at a number of staff records and saw that regular appraisals took place, which included a personal development plan. However, some staff members we spoke with said their annual appraisals were overdue.

The practice had completed reviews of significant events and other incidents and we saw these were discussed at staff meetings to ensure the practice improved outcomes for patients.