Cloisters Medical Practice

Quality Report

Cloisters Medical Practice
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Date of inspection visit: 20 February 2015
Date of publication: 09/07/2015

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cloisters Medical Practice on 20 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, responsive, effective, caring and

well- led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles, with the exception of infection control and prevention. Further staff training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said that they did not always find it easy to make an appointment with a named GP however urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

Summary of findings

- The practice provided a service to a community of people who lived on houseboats and barges. The practice offered them the opportunity to register as permanent or temporary patients and ensured that they had the means to contact and communicate with them when needed.

However there was one area of practice where the provider needs to make improvements.

Action the provider SHOULD take to improve::

Ensure that all staff receive infection control training.

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. There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable patients who used the service. There was regular monitoring of safety to ensure that ways to improve were identified and implemented. Patients who used the service told us that they felt safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Staff had received training appropriate to their roles, with the exception of infection control and prevention.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff told us that they referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Formal systems were in place to show that NICE guidelines and its implications for the practice was regularly discussed at staff meetings. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care was positive. Data showed that patients rated the practice at or above average than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff on the whole treated patients with kindness and respect, and were aware of the importance of maintaining confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England and the local Clinical Commissioning Group (CCG) to

Summary of findings

secure improvements to services where these were identified. Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good 

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. The practice had identified concerns with the reduction of services for patients with dementia and were actively looking at ways that they could address this. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 years had a named GP and was given the opportunity to nominate a GP of their choice. The shingles and influenza vaccine was offered to those older people who were eligible to receive them. A health care assistant carried out planned home visits to older people in their homes including those living in care homes .

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice held early morning and evening appointments each week.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. The practice offered longer appointments for patients with a learning disability. The practice provided a service to a community of people who lived on houseboats and barges. The practice offered them the opportunity to register as permanent or temporary patients and ensured that they had the means to contact and communicate with them when needed. The practice worked with these patients to provide care and treatment to suit their lifestyle and this included those with end of life care needs.

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 had noted that a number of their patients experiencing poor mental health had not had an agreed care plan completed. The practice had taken appropriate action to address this. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. Following an audit to review the management of patients experiencing poor mental health the practice had ensured that systems were in place to follow

Summary of findings

up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection, four of whom were members of the practice patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received. They told us that they were respected, well cared for and treated with compassion. Patient's described the staff and GPs as excellent and told us that they were listened to by staff. Representatives from two care homes told us that the practice always responded quickly to a request for a patient to be seen at the home.

We reviewed the 27 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments made were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were supportive, helpful and professional. They said staff treated them with dignity and respect, and were friendly and approachable.

The January – March 2014 and July – September 2014 national GP patient survey showed that practice performed well in the following areas.

- 90% of respondents said that the last nurse they saw treated them with care and concern as compared with the local CCG average of 83%
- 91% of respondents said that the last nurse they saw gave them enough time at their appointment compared with local CCG average of 85%
- 91% of respondents had confidence and trust in the last nurse they saw at the practice compared with the local CCG average of 89%

Areas where the practice performed less well than the CCG average were identified in the national patient survey and included:

- 56% of respondents said that their overall experience of making an appointment was very good or fairly good as compared to the local CCG average of 75%
- 57% of respondents said they were able to get an appointment when they wanted one as compared with the local (CCG) average of 74%
- 66% of respondents said that said that they would recommend the practice to others as compared to the local CCG average of 82%

Areas for improvement

Action the service SHOULD take to improve

There was one area of practice where the provider should make improvements.

- Ensure that all staff receive infection control training.

Outstanding practice

We saw one area of outstanding practice:

The practice provided a service to a community of people who lived on houseboats and barges. The practice offered them the opportunity to register as permanent or temporary patients and ensured that they had the means to contact and communicate with them when needed.

Cloisters Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team included a GP, practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Cloisters Medical Practice

The Cloisters Medical Practice was formed in April 2002 and is sited within the Greenhill Health Centre near Lichfield town centre. Other health services are also situated in the same building these include another GP practice, a pharmacy, podiatry, health visitors, community nursing, dentistry and mental health services. The Greenhill Health Centre premises are owned by NHS Property Services Limited who undertake the ongoing maintenance of the building and premises. Lichfield is one of the less deprived areas of the NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (CCG.

The practice provides services to mainly older people. This includes providing regular support and care to older people living in care homes.

The clinical and nursing team comprises four GP Partners, four salaried GPs (three male and five female), three practice nurses and two clinical support workers. A practice manager, reception, administrative and secretarial staff provide staffing support for the practice. The practice is approved for teaching medical students and is aspiring to become a training practice for GP Registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine).

The practice has a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. The practice provides general medical services to a list of approximately 8,700 patients. Services provided include the following clinics; vaccinations, asthma, diabetes and wellbeing screening clinics.

The practice does not provide an out of hour's service to their patients. It has alternative arrangements with Staffordshire Doctors Urgent Care Ltd (SDUC) for their patients to be seen when the practice is closed.

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.

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.

Detailed findings

How we carried out this inspection

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (CCG) and the local Healthwatch to tell us what they knew about Cloisters Medical Practice and the services they provided. We reviewed information we received from the practice prior to the inspection.

We carried out an announced visit on 20 February 2015. During our visit we spoke with a range of staff including four GPs, the practice manager, two practice nurses and six reception and administration staff. We spoke with nine patients this included four members of the patient participation group (PPG) who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed surveys and comment cards where patients shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- 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. For example, reported incidents and national patient safety alerts as well as 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, we saw that an incident had occurred where an error related to medicine prescribing was made by a hospital. We saw that appropriate action had been taken and the issue was raised as a significant event. Following analysis of the significant event we saw that procedures for checking medicine dose changes were reviewed, the error was discussed with the hospital concerned and policies were updated.

We reviewed safety records, incident reports and minutes of monthly significant event meetings where these were discussed. We saw that the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice and governance meetings agenda. Regular meetings were also held to review actions from past significant events. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used significant event forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of learning following significant events. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were received by one of the GPs. The GP looked at the key messages in the alert and then disseminated these to relevant staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice staff also told us that alerts were discussed at monthly staff meetings and at protected learning sessions to ensure all staff were aware of where they needed to take action. Information we read in meeting minutes confirmed this. We saw that following an alert regarding the use of a medicine used to relieve feelings of sickness or being sick, that where needed patients were called in for a review of their medication.

We saw that significant events were followed up and referred or shared with other professional agencies outside the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitored the performance of the practice told us that they did not have any safety concerns about this practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and displayed throughout the practice.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had appropriate training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. At our inspection, we spoke with a health visitor who worked with the practice. They told us that the GPs worked closely with the health visiting service to support children and their families.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The safeguarding lead told us that when they received accident and emergency (A&E) discharge letters that they were reviewed by a GP. This included identifying and reviewing vulnerable adults and children with a high number of A&E attendances.

There was a chaperone policy, which staff could access through the practice IT system. 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. Information leaflets on the role of a chaperone was available for patients and staff. Signs were also displayed throughout the practice informing patients of their right to have a chaperone present during an intimate examination. Nursing staff we spoke with told us they had received chaperone training during their nurse training. They clearly explained to us what their responsibilities were to keep patients safe from the risk of abuse. Three reception staff had received formal training to undertake chaperone duties if nursing staff were not available. These staff had DBS criminal records checks completed. DBS checks were carried out to 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 receptionists recognised the need to be able to clearly observe the examination and were aware of what action to take if they had any concerns.

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. 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.

A log of the fridges' temperature ranges had been recorded twice daily which demonstrated that vaccines in the fridges were stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff that we spoke with understood why and how to follow the procedures identified in the policy.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

We saw records of audits that identified best practice actions to be taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing for various illnesses that patients presented with such as symptoms of urinary tract infection. Action taken following the medicines audits included ensuring that all clinicians had access to a copy of the local prescribing guidelines and evidencing change in prescribing habits in line with the guidelines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat medicines were appropriate and necessary. We saw that prescription pads were stored in locked cupboards and that blank prescription forms were handled in accordance with national guidance. Systems were in place to ensure that GP prescription pads used for home visits were tracked through the practice.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there was a cleaning plan in place and records were available to monitor that cleaning had been carried out daily and in line with the cleaning schedule. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. This was also confirmed in some of the patient comment cards we received. The practice had a lead for infection control and waste management who as part of an audit had carried out spot checks on consulting and treatment

rooms. We saw information that showed that where concerns had been raised about the cleanliness of these rooms these were discussed with the practice manager who addressed the concerns with the practice cleaners.

The lead for infection control had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. However a training matrix we looked at showed that only 15 of the available 31 staff had received infection control training. The remaining 16 staff who had not received the training included clinical and non-clinical staff. We saw evidence that the lead had carried out regular infection control audits and that any improvements identified for action were completed on time. For example, plans were in place to change the type of bins used in consulting rooms to pedal bins.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they used these in order to comply with the practice's infection control policy. There was a policy for needle stick injuries and staff knew what to do if an injury occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had procedures in place to protect staff and patients from the risks of health care associated infections. We saw records that demonstrated that clinical staff had received the relevant immunisations and support to manage these risks.

We saw that a legionella risk assessment had been completed in June 2014 to protect patients and staff from harm. We saw that appropriate action had been taken to address any risks identified. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

We saw records that demonstrated all portable electrical equipment had been tested in May 2014 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in May 2014 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment and in line with the practice's policy. This included proof of identification, references, a full work history, qualifications and up to date registration with the appropriate professional body.

We saw that Disclosure and Barring Service checks (DBS) had been carried out for both clinical and non-clinical staff working at the practice. DBS checks were carried out to 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.

We saw that the practice employed sufficient and suitable staff to meet the needs of their patients. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We saw that staffing rotas were planned in advance to ensure adequate staffing levels were maintained.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that weekly, monthly and annual checks of the building had been carried out. This included a fire risk assessment and fire drills for staff; gas safety checks; emergency lighting tests; automatic doors maintenance and fire alarm testing.. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) and that an asbestos risk assessment (well managed) had been carried out in 2014.

Good

Are services safe?

We saw that where risks were identified that action plans had been put in place to address these issues. The practice manager showed us the practice's risk management report. An action log was developed and meetings were held to discuss any risks identified. Meetings were also held with the manager for the external company who managed the building. The practice had a designated lead for health and safety. All staff were issued with an employee safety handbook which contained information on safe lone working, first aid and responsibilities for safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical and non clinical staff had received or had plans in place to receive appropriate training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly to ensure it was fit for purpose.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We saw that robust procedures were also in place for GPs to sign out medicines that were needed for home visits. These medicines were then accounted for and signed back into the practice if not used.

The practice had a sub-waiting area (away from main waiting area) where patients could sit and wait to see the GP. We noted that although this was in an area where clinics took place it wasn't easily observed when consulting room doors were closed. We noted that there was no emergency call bell system for patients to get rapid assistance in the event of an emergency. The GPs told us that this would be addressed. There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required.

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 the loss of domestic services. We saw that emergency lighting checks and fire risk assessments that included actions required to maintain safety had been carried out. Records showed that staff were up to date with fire training and that a practice fire drills had been carried out last year.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example, one of the GP partners described how they had used the NICE guidelines for the management of cardiovascular disease (disease of the heart or blood vessels) in patients. We saw that the GPs and nurses used clinical templates in the management of patients care and treatment. This assisted them to assess the needs of patients with long-term conditions and older patients for example. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as ENT, mental health, gynaecology, diabetes, heart disease and asthma. The practice nurses supported this work, which allowed the practice to focus on specific conditions. We saw training certificates which demonstrated that practice nurses had received the additional training they required for the review of patients with long term conditions such as asthma, diabetes and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines.

All the GPs we spoke with used national standards for the referral of patients with suspected cancers so that they were referred and seen within two weeks. Staff ensured that these referrals were appropriately entered and coded on the patient information system.

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 patients' age, gender and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by identified staff to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last four years. All were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit to review the increased prescribing rates of an antibiotic for uncomplicated urinary tract infection was carried out. Local guidance stated that the antibiotic should only be used as the first medicine of choice for pregnant women. The aim of the audit was to identify the reason for the increase in prescribing and whether national guidance was being followed. After three cycles of this audit the practice were able to demonstrate a reduction in the use of this antibiotic as the first line of management by all clinicians. The number of patients treated and were justified as appropriate increased from 26% to 73%. Other examples included an audit on the rate of inadequate cervical smear samples and a review of testosterone (male hormone) and Prostate Specific Antigen (PSA - a protein produced by the prostate) levels in male patients who were diagnosed with diabetes. Research has shown that a number of the symptoms of low testosterone are similar to some of the symptoms of type 2 diabetes and health statistics have indicated that the two conditions may be associated with each other..

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. For example, QOF data for 2013/2014 demonstrated that the practice was lower than the

Good

Are services effective?

(for example, treatment is effective)

national average for the number of patients with diabetes with a last blood pressure reading of 140/80 or lower. One of the GP partners told us that the practice had made the decision not to intensively reduce the blood pressure of patients with diabetes to 140/80 but to use the threshold of 150/90. The practice value was 85.3% which was comparable with the national average.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 90% of patients with cancer were reviewed within 3 months of diagnosis. The data also showed that all patients with a confirmed diagnosis of osteoporosis in the 50-75 age group had received treatment. The practice had noted that patients who experienced severe poor mental health did not have a care plan completed. Information available showed that 39.6% of these patients had an agreed documented care plan in place compared with the national target of 90.4%. In response to this the practice had completed an audit for the period November 2014 to January 2015 to identify the reasons for this. The audit identified that 23 of 59 patients registered did not have a care plan recorded. Some of the reasons for this included incorrect coding (e.g. incorrect diagnosis) and patient information had not been updated although patient had received a face to face review and a documented care plan was in place. Following the audit the practice had improved their performance and ensured that 71% of patients had a documented care plan in place. The practice planned to repeat the audit in six months.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice information technology (IT) system flagged up relevant medicines alerts when the GP prescribed medicines. The pactice told us that patients' annual medication review reminders are used as a prompt to invite patients for their physical and mental health checks. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question. Where the GPs continued to prescribe the medicine they outlined the reason why this decision had been made. The practice also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Patients we spoke with confirmed that their medicines were regularly reviewed.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses took place to support these vulnerable patients. We saw there was a system in place that identified patients approaching the end of their life. This included a palliative care register of thirteen patients and alerts within the clinical computer system which ensured that clinical staff aware of their additional needs.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data highlighted areas where the practice was performing well and areas they needed to improve. For example, it demonstrated that the practice was performing well in the number of elective patient hospital admissions but the number of patient referral for pulmonary rehabilitation was low. The practice had started proactively referring patients in line with the criteria.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that some clinical and non-clinical staff were up to date with attending training courses such as basic life support. Training dates had been planned for the remaining staff to receive the training. We noted a good skill mix among the GPs and practice nurses. GPs had specialist interests in gynaecology, ENT, mental health and family planning and had completed appropriate courses and qualifications in these areas. All the GPs we spoke with 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).

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of childhood immunisations, vaccinations and cervical screening. Those with extended roles such as in coronary heart disease and diabetes management were also able to demonstrate that they had appropriate training to fulfil these roles. There was a structured programme of support for practice nurses provided by their peers who were more experienced in their roles and ongoing designated GP support was available at all times.

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 the local hospital including discharge summaries, out-of-hours GP services and the 111 service 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 communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice worked well with other local authority and health services working at the same premises. This included the midwives, learning disabilities services team and health visitors. The practice held multidisciplinary team meetings every six weeks to discuss the needs of complex patients, for example those with end of life care needs or children classed as. The meetings were attended by district nurses, social workers, community matrons and palliative care nurses. Decisions about care planning were documented in a shared care record. We saw that the practice worked with midwives to assist in the provision of antenatal care to pregnant women and also with local health visitors to support the care of babies and young children.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

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, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had a system in place for dealing with blood results. These were reviewed twice a day by a GP who was responsible for acting on the results. The practice had reviewed the format of their referral letters and redesigned these to ensure appropriate information was shared with other health professionals. Referral letters were monitored for appropriateness and data entry audited for accuracy. Referrals were also made within the practice to colleagues who had a special interest in clinical conditions such as male sexual health, gynaecology and ENT (ear, nose and throat).

The practice had started to use an electronic prescribing system to send medicine and patient reminder messages. These messages reminded patients that they needed to book an appointment with the nurse and GP.

The practice was in the process of signing up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

There were systems in place to seek record and review consent decisions. For example, where verbal consent was required for intimate procedures, a patient's verbal consent was documented in their electronic records. For other procedures, including minor surgery and therapeutic injections, written consent was obtained. We saw a form that patients signed to acknowledge that the procedure, the benefits and risks had been explained to them before they gave their consent. We saw that patients had signed consent forms for children who had received immunisations. The practice nurse was aware of the need

Good

Are services effective?

(for example, treatment is effective)

for parental consent and what action to follow if a parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

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 to. The plans included details of the patients preferences for treatment and decisions. Staff at the practice told us copies of the care plans were kept in their homes. Some of the patients we spoke with confirmed this.

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. We saw that where there had been best interest meetings that were documented with details of the outcome. All clinical and non-clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We saw that staff had attended recent training on mental capacity and DoLS (Deprivation of Liberty Safeguards) The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Health promotion and prevention

It was practice policy to offer an annual health check to all new patients registering with the practice and patients aged 75 years or over. The practice offered three yearly NHS Health Checks to all its patients aged between 40 to 74 years who were not already diagnosed with diabetes, heart disease, and stroke or kidney disease. These checks included a cholesterol test, blood pressure check, weight and lifestyle management advice. The GP was informed of all health concerns detected and these were followed up in a timely way. We saw notices in the waiting room that made patients aware that these health checks were available. The practice actively engaged their patients in lifestyle programmes. The practice had recorded the smoking status of 83.7% of their patients over the age of 15 this level was similar to the local and national rates. The practice nurse described to us how they sign posted patients to smoking cessation courses, 67.1% of patients who smoked were receiving support.

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was in line with the local Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations. The practice offered travel vaccines and flu vaccinations in line with current national guidance. The Quality Outcome Framework (QOF) data showed that the practice was performing above national standards in providing flu immunisations for the target groups of patients.

There were systems in place to support the early identification of cancers. Information we reviewed showed that the uptake of female patients aged 50-70 years screened for breast cancer within six months of invitation was 81.5% as compared to the national average of 73.6%. The practice carried out cervical screening for women between the ages of 25 and 64 years. Patients who did not attend for cervical smears were offered various reminders, by telephone and letters for example and the practice audited non-attenders annually. The practice offered a free and confidential Chlamydia screening service for all 16 to 24 year olds. Family planning services were provided by the practice. Free condoms were also available.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept registers of their patients who would be considered at risk and or vulnerable. These included a register of patients with learning disabilities, however a register of patients with mental health problems was not complete. Patients with a learning disability had a care plan completed and all these patients received an annual physical health check by the practice. The practice told us that they had 48 patients with dementia registered with the practice. These patients had a care plan developed with the involvement of other health and social care professionals.

Good

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 information from 142 replies to the national patient survey carried out during January-March 2014 and July-September 2014. The evidence showed that patients were generally satisfied with how they were treated. The results from the national patient survey showed that 73% of respondents said that their overall experience of the practice was good or very good and 66% of respondents said they would recommend the practice to someone new to the area. These results were below the Clinical Commissioning Group (CCG) average of 88% and 82% respectively. However the outcome of a family and friends test in January 2015 showed that 91% of patients that responded were extremely likely or likely to recommend the practice to others. The practice was also slightly below the local CCG average for its satisfaction scores on consultations with GPs. For example, 79% of respondents said the GP was good at listening to them and 76% said the GP gave them enough time. The CCG average was 89% and 88% respectively. However, the practice was above the CCG average for its satisfaction scores on consultations with nurses. For example, 90% of respondents said the nurse was good at listening to them and 91% of respondents said the nurse gave them enough time. The CCG average was 83% and 85% respectively.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 27 completed cards and they were generally positive about the service they experienced. Patients said the staff were understanding, helpful, polite, nice and that staff treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff that we spoke with were aware of the difficulties but had systems in place to maintain patient's confidentiality. These included taking patients to a private room to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the practice for investigation results.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. 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 they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responses to questions about their involvement in planning and making decisions about their care and treatment generally rated the practice as good or very good in these areas. For example, data from the national patient survey showed 69% of practice respondents said the GP involved them in care decisions and 74% felt the GP was good at explaining treatment and results. Both these results were below the CCG average of 76% and 84% respectively.

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 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 that the practice had developed a chronic disease management leaflet for patients. The leaflet provided patients with information on the frequency of reviews that would be carried out dependent on their illness. The leaflet also told patients what equipment, medication or specimen they should bring with them when attending their review appointment. For example, patients who had diabetes were told to bring an early morning urine specimen, their home blood pressure (BP) and glucose monitoring equipment when attending their annual review.

We spoke with representatives of two care homes for older people. They told us that all the patients living there who were registered with Cloisters Medical Practice had a named GP and received regular medication reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNARCPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and significant others. People are able to make the decision that they do not wish to receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. We saw that where a DNARCPR decision was in place this was entered in patients electronic records and both the practice and nursing home had copies. This information was also shared with the out of hours (OOH) service where appropriate.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 74% of respondents to the national patient survey said the last GP they saw or spoke with was good at treating them with care and concern with a score of 90% for the nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

We saw that patient electronic records had the name of their carer documented where this was applicable. The lead GP told us that patient deaths were recorded in the patient electronic record and also details entered into a book so that staff were notified of the death. If families had suffered a bereavement, their usual GP contacted them and a 'face to face' visit arranged if patient wanted this. If necessary, they also signposted them for bereavement support and counselling provided by the local hospice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood for example, the practice held a register of patients identified as homeless. The practice also provided a service to a community of patients who lived on houseboats or barges. If the practice needed to contact these patients to discuss their care and treatment they could do this through PO Box addresses, email or text messaging. This group of patients were offered four monthly prescriptions where appropriate to meet their needs and support their way of life. The practice had identified that they had a problem with providing continuing end of life care for patients who lived on houseboats and barges. To support this the practice had systems in place to share information with other health professionals that these patients may be in contact with when travelling. The practice had a small number of patients who misused substances, these patients were referred to local treatment and support services.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with four members of the PPG who told us about the patient survey in 2014 of 240 patients and the results of the family and friends test completed by 91 patients. They told us that concerns had been raised regarding the need for more appointments, the difficulties in getting through to the practice, communication at the practice and that a simple method of making compliments and suggestions was needed. We saw that the practice had addressed these concerns for example we saw a compliments and suggestion box in the waiting room, a seasonal newsletter was introduced for patients and regular news updates were made on the practice website. To provide an immediate response of the survey outcomes to patients the practice introduced a 'You said – We did' newsletter.

Tackling inequity and promoting equality

One of the GPs was designated as the lead for equality and diversity within the practice. The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified when the training would need to be updated.

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground floor of the building. Although at times the waiting area was very busy, it was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included disabled parking spaces; level access to the automatic front doors of the practice; disabled toilet facilities and a hearing loop for patients with a hearing impairment.

The practice had a small population of patients from Eastern Europe and Asia. For patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care. Some of the staff at the practice also spoke several different languages which included German, Russian and French.

The practice provided care and support to several house bound elderly patients and patients living in local care homes. Patients over 75 years of age had a named GP to ensure continuity of care. We spoke with representatives from two of the care homes who told us that the practice always responded quickly to a request for a patient to be seen at home.

The practice provided care and treatment for a community of people who lived on houseboats. They told us that this community were supported to register as permanent or temporary patients with the practice whichever was more appropriate. The practice held a register of 16 patients with a learning disability registered with the practice and all of these patients had an agreed care plan in place to support their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Comprehensive information was available to patients about appointments on the practice's website and in the practice leaflet. This included how to arrange routine and urgent appointments and home visits and how to cancel appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

We looked at the national patient survey results published in January 2015 and saw that 56% of respondents described their overall experience of making an appointment as good or very good compared with the local CCG average of 75%. Some of the patients we spoke with and comments made in comment cards said that making appointments was sometimes difficult. Some patients commented that it could take several weeks to get a pre-bookable appointment with their GP of choice. The practice was aware of these concerns and had identified that some of the problem was related to the telephone system used. The practice was in the process of changing to a new telephone system and had introduced online booking of appointments for patients.

The normal opening hours for the practice was 8.00am to 6.30pm and appointments were available between 8.30am and 6.30pm. The practice also offered extended hours outside of the practice normal working hours for patients unable to attend due to work commitments or rely on other people bringing them to the practice who go to work. Extended hours were offered with a GP and a nurse on a Monday evening (18.30 - 19.30) and early morning surgeries on a Tuesday morning (07.10 - 08.00).

The practice offered pre-bookable appointments which made up to two weeks in advance. These appointments were for patients who need to be reviewed by a GP on a regular basis and those who did not need to see a GP urgently. For those patients who wish to be seen on the same day systems were in place for the designated duty GP to contact the patient by telephone to assess the persons clinical needs and make a decision as to whether an appointment was needed. The patient would then be booked an appointment to see the duty GP. The practice also offered patients the opportunity to contact the practice nurses by telephone for advice at any time during the day. If the practice nurses were busy they would return the call that day.

Longer appointments were available for patients who needed them this included those with long-term conditions. The practice offered up to five telephone consultations per day after the morning clinic. Staff told us that children and older patients were always seen on the same day that they requested an appointment. Patients were given a four week appointment following the discussion of a minor surgery procedure. This provided patients with the opportunity to make an informed decision about the procedure.

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 there was information on the practice website and a poster in the waiting room informing patients how to complain.

We looked at 29 complaints the practice had received between April 2013 and March 2014. and found they were responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. We saw practice meeting minutes that demonstrated complaints were a regular agenda item and learning from them was shared with staff. This supported staff to learn and contribute to any improvement action that might have been required.

The practice reviewed complaints to detect themes or trends. We looked at their annual complaints review report. We saw that lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver 'high standards of care and provide excellent services for patients, staff and the wider healthcare community'. We found details of the vision and practice values were part of the practice's three year business plan. The practice values included to provide people registered with the practice with personal health care of a high quality and to seek continuous improvement on the health of the practice population; to recruit, retain and further develop a highly motivated and skilled workforce; to treat all patients and staff with dignity, respect and honesty and to maintain high quality of care through continuous learning and training.

We spoke with a number of patients, staff and other health professionals who all spoke very positively about how the practice worked to fulfil its aims. Staff and members of the PPG told us that the practice continuously reviewed the services provided and introduced changes if they were appropriate to meet the needs of patients. We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw that staff demonstrated a positive approach to the practice aims and comments from patients we received aligned with this. We spoke with representatives from two care homes where the practice provided care and support to patients and they confirmed that the practice worked in line with these values.

The practice offered services that supported improving outcomes for patients. Patients were provided with the opportunity to be treated closer to home or at their home. These services included the initiation, monitoring and reviewing of insulin treatment for diabetic patients, carrying out diagnostic tests which included taking bloods and carrying out an electrocardiogram the process of recording the electrical activity of the heart (ECG), minor surgery and the identification and monitoring the 2% of patients at high risk of unplanned admission to hospital.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer at the practice. We saw that staff could easily access the policies. We looked at seven of the policies available and saw that they had been reviewed annually and were up to date. The practice collected evidence to confirm that staff had read and understood relevant policies that had been put in place. This was monitored by the practice manager and was also followed up at practice meetings and through staff appraisals.

There was clear strong leadership at the practice. Staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns. All staff had specific roles and could demonstrate that they took these seriously. For example, there was a lead nurse for infection control who ensured that audits completed involved all members of staff. We saw that a recent review of hand washing techniques included observations of GPs, administration staff and nurses. A female GP led on women's health with a special interest in gynaecology (the medical term for dealing with the health of the female reproductive system). The 2013/2014 Quality and Outcomes Framework (QOF) data we looked at showed that the practice had received a practice value of 100%. The practice had a protocol in place to effectively manage cervical screening, this included staff training and an effective call and recall system as was shown by their exception rate which was lower than the national average. Other lead roles included clinical and information governance, mental health/dementia and teaching.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed it was performing in line with national standards with a practice value of 82.1% compared with a national value of 93.5%. We saw that QOF data was regularly discussed at monthly governance meetings. We saw that actions had been taken to maintain or improve patient outcomes. These included a review of the care of patients who experienced poor mental health .

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at six completed audits all of which demonstrated improvements in outcomes. One example was an audit to check the testosterone levels of male patients with diabetes. Research showed that low testosterone levels were more common in men with diabetes and this could have an

Are services well-led?

Good

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

adverse effect on their quality of life. The audit looked at patients level of testosterone and made appropriate changes to their medicines and ensured annual checks were carried out in line with recommended guidance. The audit had been shared with all staff and included discussion and peer review of each case. As a result learning had been shared between staff.

The practice had arrangements for identifying, recording and managing risks. The manager for the premises and the practice manager showed us the risk log, which addressed a wide range of potential issues, for example loss of the computer system. We saw that the risk log was regularly discussed at meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. In the event of the loss of the main computer operating system, practice staff had identified alternative computers and installed a back-up computer system to allow staff to access patient information and guidelines.

The practice held monthly governance meetings to which all staff were invited. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and disciplinary procedures 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, whistleblowing and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. The practice had a whistle blowing policy which was available to all staff to access by the practice intranet. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients through surveys, comments, complaints and review of the GP national patient survey. The practice had a small but active patient participation group (PPG). The PPG had eight members which mainly represented the over 60 age group. The PPG was actively attempting to recruit and we saw notices advertising this displayed in the practice. The PPG members we spoke with told us that potential members were interviewed by two members of the group. The PPG had carried out yearly surveys and met every three months with practice staff including the practice manager and a GP. The practice manager showed us the analysis of the last patient survey. The minutes of the PPG meetings showed that the outcome had been discussed with the PPG. One of the outcomes of the survey showed that patients had expressed that they needed ways to improve communication with the practice. The practice implemented a comments/suggestion box, regularly updated practice news on the practice website and started a practice newsletter. The effectiveness of these had not yet been reviewed. The practice published information from the survey on noticeboards by way of a 'You said… We did' poster and on the practice website.

The practice had gathered feedback from staff through appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

The staff we spoke with told us that they had been supported to develop skills and knowledge appropriate to their role. This was confirmed by the training certificates on staff files. We saw that nursing staff had completed additional qualifications and updated their skills to enable them to support the management of patients' health needs. An example was some nurses were trained to manage the treatment of patients with asthma. Reviews for patients with asthma and emergency admission data showed an improved outcome for these patients than the national average. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a

Are services well-led?

Good

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

personal development plan. Staff told us that the practice was very supportive of training and that they had monthly protected learning time. Learning was regularly shared and applied at all staff levels.

The practice was approved for teaching medical students and is aspiring to become a training practice for GP registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine). The practice was awaiting an approval visit to take this forward.

We saw that the practice also promoted self care to patients by displaying health promotion information throughout the practice. A member of staff was responsible for maintaining the patient notice boards. These were presented in a user friendly manner. Topical themes were used for each noticeboard which included for example information on heart conditions and these were updated on a regularly. One of the displays briefly described how the heart worked, signs and symptoms the patient may experience and what to do if they had concerns. The notice board was educational, pictorial, and neatly displayed in a flow chart manner so that the patient could follow the 'story'.

We saw that the noticeboards attracted patients attention. Patients told us that they found the information easy to read and understand. The boards were easily accessible to patients in the corridors and waiting areas of the practice. Other topics covered included advice on keeping warm in the winter months and diabetes. One of the GP partners and the practice manager told us that the contents on the boards were changed regularly to cover topical areas related to health and promoting self care. The practice had also developed their own series of information leaflets for patients covering topics such as chaperones and the named GP for patients aged 75 and over. Practice staff told us that one of the patient information leaflets explaining the 'Urgent 2 Week Wait Referral Leaflet' was being adopted by the local clinical commissioning group.

Reflection, teamwork and improvement were recurrent themes we saw and heard whilst carrying out our inspection. The practice GPs met on a weekly basis to discuss any clinical issues, guidelines or serious events. We saw evidence that where although there was a high level of performance that where there was poor performance this was addressed both through the practice staff team and the patient participation group. Staff showed they were keen to ensure ongoing improvement and addressed this as a team. An example of this was a review of the care provided to patients who experienced poor mental health. The practice also had plans going forward to review the services provided to patients who had been diagnosed with dementia due to the impact of the withdrawal of community support services for this group of patients.